MENTAL HYGIENE

VOL. XXXIX APRIL, 1955 No. 2

EDITORIAL

MARGARET H. WAGENHALS

THE National Committee for Mental Hygiene was less than ten-years-old and MENTAL HYGIENE barely on its way, when Margaret H. Wagenhals joined the staff and became its Assistant Editor. Upon her shoulders has rested the main task of administering its publication. But even more, her sense of what is important and her capacity to use technical consultants has given the periodical its position as a guide to the mental health leadership of this and other countries. She has held it to the lines of a scientific journal open to divergent viewpoints as contrasted with a house organ. She has chosen wisely the books to be reviewed and the reviewers of books, a service of the journal that has achieved an important place in a world that is so abundantly supplied.

Now with the completion of the January issue, Miss Wagenhals has retired to do the many things she has wanted to do. She now becomes one of the consultants whose labor of love has meant so much to the journal. May she enjoy the much deserved freedom from galleys and may her successors be inspired by her steadfastness to the principles of a scientific publication.

GEORGE S. STEVENSON
Editor

SOLVED AND UNSOLVED PROBLEMS IN MENTAL HEALTH*

H. C. RÜMKE, M.D.
Utrecht, Holland

"SOLVED and Unsolved Problems in Mental Health"—that is what Professor William Line, Chairman of the Program Committee, suggested as the theme of this address. This has presented a challenge of which I am well aware. Dr. Line knows that I have constantly drawn to the attention of the Executive Board of our Federation the great uncertainties we have, and that I have insisted unremittently on the unilateral character of many a thesis considered as a certainty. At the commencement of my activities with our Federation, I was skeptical to a high degree, but in the course of the past six years I have become one of the most optimistic regarding our ultimate goal. To the question: "Do you believe in the goal which the Federation visualizes?", I reply, "Yes," with all my heart. Is it that I have lost my skepticism? Have I now decided to believe in that which many of us accepted as the foundation of our movement? That is what my friend Line wanted to know, and that is the challenge which I accept.

What we wish to know.—Since it is necessary to outline the position, I wish at first to define the area. What is the object of the mental health movement? What do we wish to study? What do we wish to remedy? These are questions which have been asked a thousand times already, and to which one would suppose we had finally found a unanimous answer. But that is not so. That is foremost among our outstanding problems. The work of mental hygiene is at one and the same time extremely vast and of an extremely complicated structure. In Baghdad we wish to improve the aid for the insane; we wish to teach employees of the Post Office in Holland to be more polite to the public; but at the same time we wish

* Presented at the Fifth International Congress on Mental Health, Toronto, Canada, August 17, 1954.

to improve the relations in a factory in Buenos Aires, and to teach the teacher in Finland how he ought to behave with his pupils. We wish to know why the number of suicides in the United States is higher than in Ireland; and we want to teach mothers everywhere in the world how to care for their children. We undertake to assuage the grief of a lonely woman, and to prevent war. That is a fascinating program! And someone asks us, "How do you propose to bring about all that?" But that is very easy; we propose to make the principles of mental health triumph among the doctors and nurses of Baghdad, the employees of a Netherlands' city, the industrial workers of Buenos Aires, and the "Big Four". You are going to say to me, "You are joking and teasing us." And I reply, "Not at all. That is precisely what we wish, and there is no way of explaining it more clearly. That is what we want; no more, no less." Moreover, you can find it in the reports of our congresses and again in our excellent Preparatory Commission "statement". I am not joking, this statement is one of the most esteemed documents issued by our movement. We desire all that, and it is necessary that we desire it in a strong manner; we cannot allow ourselves to be diverted by lack of funds, by success in the minds of stupid people, or the fear of ridicule. And actually, we are not ridiculous if we do not allow ourselves to be carried away, and if we maintain our critical and skeptical attitude toward current certainties.

Mental Hygiene.—Our field of work is made up of two parts, the inter-relationships of which is one of our problems. The mental health movement has developed out of the mental hygiene movement. You know the facts. For mental illness, as for all others, one seeks means of prevention, and for better care during and after hospitalization. Then notice was taken of juvenile delinquency and the importance of youth; and these things were gone into. Specialists of different branches contacted each other and there was born the "multiprofessional team". (Let us note here that it is a question of the prevention of illness. We do not know, it is true, what that illness is precisely, but that does not prevent us from being able to rejoice in the remarkable success.) Soon the battle against alcoholism was included in the program; and the treatment of mental deficiency, and child psychiatry

followed. Because it was formerly a question of medical involvement, the doctor became the incontestable head of the team.

It would be too much to pretend that all problems in this field are solved, but a trend has been delineated. Here also, there is a possible comparison with other medical problems, and at the congress in Brussels Dr. G. R. Hargreaves said some very interesting things on this subject. Notably he said: "Mental health work should consist in the attempt to remove from the human environment those factors which are harmful to health, and, on the other hand, to provide those factors which support and promote health." In concerning ourselves with mental health, we have a double task: "First, we must act on what etiological knowledge we have to protect individuals and particularly children from experiences which are noxious, and to provide experiences which are necessary, or supportive to the fullest and healthiest development of the individual." (For this Hargreaves used as a basis the studies of Spitz and Bowlby on "maternal deprivation", heaven-sent studies, studies of which everybody boasts, and with which many mental health workers have revived declining enthusiasm.) Secondly: "From the epidemiologic study only can we hope that mental health work will diminish the sum total of mental sickness which afflicts our communities, and see, in the field of mental health, victories over disease comparable to those which our colleagues in physical hygiene have won over the epidemic diseases in the Western world." The subjects of study which Dr. Hargreaves proposes are, among others:

"The prevalence of psychiatric disorders, for instance, among tribal Africans appears to be very much lower than in the Western countries. France, a wine-producing country, appears to have a rate of alcoholism about five times that of Italy, also a great wine-producer. Suicide is about eight times as frequent in the U. S. A. and Denmark as it is, for instance, in Ireland. Peptic ulceration which was the woman's disorder fifty years ago, is now a disorder of men."

I cite the ideas of the competent head of the psychiatric section of the World Health Organization. These are excellent projects, but let us not forget that the World Health Organization is a medical organization, which treats health in a positive manner certainly, but nonetheless medical. Medi-

cal mental hygiene needs as well the collaboration of other specialists, such as public health officers, statisticians, economists, engineers, etc. Evidently, here also, there are solved and unsolved problems, but these are concrete problems. The etiology may be debatable, but the exogenic mental illnesses, the consequences of infectious illness, the metabolic illnesses, cerebral illness as for example encephalitis, remain well-defined realities. Puerperal psychoses have practically disappeared. Syphilis maintains a certain importance in the etiology of psychoses. But, once again, these are well defined tasks. The fight against alcoholism has been taken up again; some seminars have known brilliant success. The great problem which presents itself here is fundamentally the problem of psychiatry itself. Psychiatry, which apparently is in full flower, is more than ever in danger. Offshoots are detaching themselves from the mother science and are developing in a unilateral manner. American dynamic psychiatry separates itself from European psychiatry, which is older, more clinical, but which has retained its importance. Nosology is being neglected; one is no longer conscious of the relativity of diagnosis, and contact with the neurophysiological and biological points of view is lost. (I shall be talking later of neuroses and psychotherapy.) Finally we do not know enough about the professional illnesses of psychiatrists, but all that does not alter the fact, I repeat, that in the field of mental hygiene there is an incontestable progress.

Mental Health.—Until 1948, the word "mental hygiene" was maintained in the name of the Federation. At the Congress in London it gave place to the word "mental health" and thus the "World Federation for Mental Health" was born. The program also was enlarged. In the army, one learned that it was possible to improve the morale of a group by scientific methods, that the relationship between leaders and subordinates was of prime importance, and that there was occasion to apply the principles of depth psychology (*Tiefenpsychologie*). From this research there developed, thanks to Dr. John Rees *et al.*, the following idea: If methods exist to improve morale in the army, is there not a method, based on that which we have learned in individual psychotherapy, of raising the morale of the whole of society? This question was completely justified, only it was no longer a question of mental

hygiene; it was a question of normal man, of his situation and his potentialities. It was a question of things of which the psychiatrist was no longer the first judge.

At the Congress in London, it was perfectly clear that the old mental hygiene movement was changing direction. The old topics were no longer satisfying; and the great problems were: "guilt and aggression," "individual and society," "mental health and world-citizenship," "world citizenship and good group-relations," "family problems and psychological disturbances," "mental health in industry and industrial relations," etc. This change and the enormous enthusiasm that was forthcoming were born out of the necessity of the moment. It was clear that the Congress had a socio-genetic root; and many people had their attention drawn to it at the same time.

Mental hygiene and mental health are in principle two different fields. Our federation had to do with both. There, to my mind, we see the first great problem. Is this problem solved? First of all, I permit myself to say that it is my personal opinion, and I repeat, as I have done each year: mental hygiene and mental health are different in principle. If, in mental hygiene, the psychiatrist should be the head of a multiprofessional team, in mental health he has only a secondary rôle to play. Is this opinion tenable? Personally, I am convinced that it is, but I confess that that which appeared to me so clear and certain at the meetings of the Executive Board was acceptable to few. This gave me much thought, and in that which follows I wish to carry my ideas through to you.

In my estimation, actually it is a problem of prime importance. I do not believe I am exaggerating in saying that here we are touching upon *the central problem, upon a good part of which depends the solution of all the problems in the two fields. It is no less than the question of the relationship between sickness and good health.* You are going to say, "That is not the point. That is an outmoded opinion. Health is not an absence of sickness; one must conceive of health in a positive manner." But I reply that that is what I am doing. It is precisely when health becomes more than the absence of illness that the problem springs. From then on, it is impossible to protect and promote health in combating illness, *then it*

becomes necessary to know the laws of health, the bases upon which they are founded, and the forces which control them. Now, these forces and these bases are not known by us. We do not know what is essentially health.

Tell me, do you admit that you reject everything we have learned from *Freud*? In Vienna you have just rendered him homage as one of the greatest of all time. Actually, that is what I did, and Freud taught us a lot, *but not on the subject of psychical health.* He showed us an end of the road—not a small task—that one must follow in the treatment of neuroses. You insist, "Don't you know that there exists between health and sickness an almost imperceptible progressive transition, and consequently an understanding of neuroses is, in itself, an understanding of man." I retort, *"But no, that is exactly what I do not accept."* This transition is not proven and one who understands neurosis does not necessarily understand other illnesses, nor the man in good health. This is one of the temptations, I believe, to which psychiatry might succumb. A psychiatrist, who for many long years has been intensively concerned with a great number of disturbed men, runs the danger of believing himself competent with regard to the normal man. Do not blame him for that; the saying that "in the psychically-disturbed man one sees that which is human as through a magnifying glass" has common acceptance. But may I say distinctly: *It is my firm conviction that the understanding of the disturbances of the sick man hardly contributes to the understanding of the normal man.* Too often we confuse the psychically disturbed life with the greatest depth of being—this is a *professional malady typical of psychiatry.* Doubtless we catch a glimpse of unfathomable depths; doubtless at one time or another (but not often!) the depths and the heights of human possibilities become visible to us, but these are pathological depths and heights. The artist discloses and shapes the most profound life, not the psychiatrist. This life *never appears in ill man,* but *appears in supreme moments of the normal man.* These moments are of short duration. Soon life falls back to the ordinary level; a level more or less satisfying, according to the temperament in question. Going down again, life shuts itself, and that is precisely the characteristic sign of normal. The life of the mentally ill remains open, yawning; remains visible, shame-

less, clarified in a strange manner, insane. The pathological case lacks form, style. It becomes evident *that the difference between illness and normality is a problem of form.* The psychiatrist who by his psychiatry believes himself to be a connoisseur of men runs the risk of badly judging normal man and he is *not seeing that which is missing in the ill. And it is precisely the question to find that which he lacks, that which is absent:* that is to say, the great human qualities of love and creativity. If there were a means of distinguishing more clearly still, the difference would become more clear to us between that which I call the psychic disturbances of normal man and those of the sick man.

It is possible to say that the psychic life of a normal man is greatly disturbed without having the right to declare that this man is ill. *It is an attack on human dignity to call his struggles and his downfalls "illness".* Man has his almost insupportable tensions and his spiritual exaltations, but he knows also profoundly disconcerting experiences, mistakes and regret, loss of love; he knows offended honor and stresses which cause him to sink to the lowest depths. This is the unceasing torment: the combat with disruption, the battle against anguish and pride. Let us guard against calling all this illness. Psychic disturbances to the extremes of the normal and the pathological are due in large measure to the fact that man is not sufficiently equipped from the biological point of view to cope with his difficulties. Then appears the human conflict in its pathological form, then man is ill.

To be fair I must add that, if the psychiatrist is not *eo ipso* a connoisseur of men, one who understands the normal (I am not thinking primarily of psychologists but of the great "intuitive ones"), he does not understand *eo ipso* the psychically disturbed life. The enormities which certain ones allow are far from our fault. If it is true that we project in the normal man our knowledge of the ill, that is not serious; normal man can easily withstand the blow. But if, on the other hand, the normal man peacefully projects, without consideration, his psychology on the sick, it will be overwhelming to him.

We are now in a position to draw a supposition of some sort as to what health is: it is a question of creativity, of love, of form of life, of a current without stagnation, or a rhythm of opening and closing; it is a question of regulation, of

adaptation and of "tension psychologique." Health is also a question of the distance between the experiencing ego and what has been experienced, an aspect studied little up to the present time. Finally, and this is what always strikes me, life is less a question of content than of form. In the event of a close examination, we meet the most bizarre contents in the life of the most normal man; we encounter them also in ourselves. Basing our judgment on the content, we would call "ill" most of the men who are apparently normal. That would mean inversely: *the contents do not allow one to diagnose between ill and normal.* (It is evident that I do not deny that a certain content may make us *suspect* certain maladies, but it remains that the most astonishing parallels between primitive ideas and those of schizophrenics do not contradict this thesis.)

If illness is a problem of form, then the undetectable transitions lose a good part of their likelihood. But if it is true that these transitions do not exist, that health possesses its own structure, a form of its own, a qualitative modus other than illness; if health is a state which may be disturbed, without for all that becoming ill, then the difference between the task of "mental hygiene" and that of "mental health" ought to be even greater. Then, and this is especially my opinion, the psychiatrist is no longer of specific competence to deal with the latter. It is possible that he may be interested in the problems of mental health—and I count myself among them—but the solution of these problems no longer depends upon him. Moreover, if I run over with you once again the topics of the Congress of London, it is necessary to say that they are not psychiatric topics: neither "world citizenship and good group-relationships," nor "mental health in industry and industrial relations," nor the subject "family problems and psychological disturbances," nor "individual and society." I deny the competence of the psychiatrist in this field, but there is perhaps more: *it may be that, by his attitude and by the means at his disposal, he becomes a danger for mental health. We must resolve this problem, if we wish to avoid the possibility of our entire movement running a grave risk.*

Whence comes the idea that the psychiatrist is good and competent enough in this field? I see among others: (1) the idea of imperceptible transitions, and (2) the fact that he

does not stick closely to the definition of mental health. That which he does—and I return again to that which I cited of Hargreaves a little while ago—that which he does is indisputably to prevent illness. In this sense we find ourselves in an ambiguity. Then we ought to hold openly to the absence of illness as the definition for mental health, and then mental hygiene and mental health become one. And if we reject the imperceptible transitions we can interpret all conflicts, all disturbances as being slight forms of illness. But it is precisely this, I repeat, that I wished to combat.

All the preceding has much importance because the majority of means at our disposal which may exercise an influence on men comes from the treatment of the sick and especially of neurotics. (May it be said that the lack of precision in the knowledge of neurosis contributes to the uncertainty. It is important to establish that the neurotic syndrome is encountered in general in the sick, but from time to time in normal cases, which complicates still further the already difficult conclusions concerning the success of treatments.) In brief, it is a question of knowing if the methods which we use for the sick are valid also for the normal. If such is the case, the psychiatrist automatically reassumes his competence in the field of mental health in the strict sense. *It finally becomes a question of an evaluation of depth-psychology (Tiefenpsychology) entirely. That is to say of our dear "psychodynamics" and of the limitations of psychogenesis.*

Depth-Psychology.—We consider as resolved the question as to whether this psychology has given us the greatest contribution to the knowledge of man. This does not alter the fact that there are a number of terrible problems awaiting solution. The term *Tiefenpsychology* was introduced by Bleuler, indicating with this word the psychoanalysis of Freud. Since then, this term has been used more and more to indicate the teachings of Freud, Jung and Adler. Even though it has been popularized and is defensible, I do not believe that the term is a suitable one. Its greatest inconvenience is that the word "depth-psychology" evokes an antithesis "surface-psychology," which in turn has a qualitative association "superficial." In that way, the misconception is introduced that depth-psychology was revealing to us a deeper knowledge of man than other psychological methods. Depth-psychology

is concerned with unconscious psychic activities, while other psychologists treat of the phenomenology of conscious existence, of human behavior, of contact with others, and of man in his different situations. Now the study of this conscious, of man "in a situation," is able to lead us to a knowledge as deep, if not more so, as any method of depth-psychology, no matter what method it may be. It is always useful to bear this in mind.

A more detailed study of the problem would lead us too far. Let us not dispute over a difference of value, but let us rejoice in the possession of depth-psychology, and hope that beside it will develop an important surface psychology, which may concern itself with the problems of form of the psychic life. Man reveals himself most in his developed, mature, outside appearance, in his psycho-physical manifestation.

What concerns me at the moment, is that the schools of depth-psychology have in common the fact that the human psyche is more and other than its surface manifestations, its conscious, its content and its deeds; that surface manifestations are not at all comprehensibles in themselves, but refer to motives and forces active in the unconscious. In that connection—and Stern has said it—already two new tasks present themselves to scientific psychology: (1) the study of the relationships between the surface of consciousness and deep unconsciousness, (2) the task of elucidating the essence of this depth. The three schools of depth-psychology had in view, moreover, this double goal, and all three arrive at the conclusion that the content and motivations of the conscious are at the same time an expression and a covering disguise of the unconscious content and motivations. On this point they are all in accord, and the problem no longer exists. Only, since it is not possible to analyze everybody, interpretations become inevitable. And these interpretations depend in large part on that which in the unconscious one accepts as active forces. And there is where the problem remains complete. Actually in comparing the instinctive bases of Freud, von Monakow and MacDougall among themselves, in comparing them to the archetypes of Jung and to the existentials that might be introduced further, one must conclude that the interpretations of the depth-psychology remain almost impossible at the moment and thus

that, in spite of psychoanalysis, we remain almost ignorant as to the directive forces of man. It is, in fact, of utmost importance if one admits to a social instinct, an instinct which carried to the extreme values, as Klages does, if one considers religious inclination as a primary tendency (as I do, for instance) or as a secondary tendency to be deduced from something else. We cannot take this system of directive forces too seriously. If we content ourselves too quickly with too limited an instinctive basis, we distort man and are far from contributing to his mental and spiritual health. This *anthropological uncertainty* is the weak point in all depth-psychology and all doctrines of dynamic psychology in general. And the problem can only be resolved by a collaboration of numerous groups of specialists who at the moment work entirely separately. And let us not neglect the philosophic problem: Many authors write unflinchingly that the psychosomatic problem is resolved, that psyche and soma are interpenetrated, interimpregnated one with the other, and that to speak about this is only useless quibbling and outmoded. This problem is *not* resolved, the problem of psychosomatics no more than the problem of directive forces. The problems of spiritual forces, which escape biological description, see themselves completely repudiated in our contemporary psychodynamic doctrines. As long as we are on this subject, in the application of these doctrines in the field of mental health, extreme prudence will be the strict rule.

Another problem, which again further underlines the difference between mental health and mental hygiene, is that of the limitations of psychogenesis. Here again I cannot linger, and I shall suffice in laying stress on the problem, which at the Congress hardly figures in the program. It is my personal opinion that psychogenesis operates mostly in the field of normality. It is in this respect that I declare myself to be completely in accord with Mr. Henri Ey, under whose direction there was an interesting symposium on this subject. Here perhaps the admonition is appropriate to pay more attention to the extremely important French psychiatry. Inasmuch as it is good mental health not to forget the findings of other countries, I ask you in all sincerity: in the Anglo-Saxon countries, who reads authors such as Ribot, Janet,

Claude, Delay, Henri Ey, Heuyer? All are indispensable authors for an exact integration of psychiatry.

Neurosis in the strict sense is only very partially psychogenic and psychosis is even less so. That which is important is that among the factors which condition the morbid state, even in a somatic illness, psychogenesis remains one of the most important. This is why I hope that once the psychosomatic overestimation fades, we see more clearly that if psychogenesis does not provide a means of curing completely, it is keeping its value for the assuaging of even the most grievous conditions.

"Psychodynamics" are not the decisive factor in man.— Now we have arrived at this conclusion: psychogenesis operates mainly in the field of the normal. This allows us to admit that in the field of mental health psychodynamic factors are of great importance and that in general we are able to consider the latter as the ground where, basing ourselves on the knowledge of these factors and taking into account our uncertainties, a favorable influence becomes possible. But there is a further problem which awaits solution.

The problem is that of knowing what is decisive for the psychic health of man: is it the nature and the coöperation of his directive forces, his "dynamics," or his constitution, his psychological type, his "tension psychologique"? As long as this problem remains unsolved, we run the risk of wasting our time and our energies on useless endeavors to change the "psychodynamics." The problem of neurosis is again unresolved. As long as we persist in calling everything neurosis that causes difficulties in life, so long are we wasting time and money beyond measure. You ask me: "Aren't you exaggerating; aren't you perpetrating the fault with which you reproach us?" I do not believe so, and on the basis of years of clinical experience, psychotherapeutical and psychoanalytical practice, I dare to repeat: This problem exists. And again on the basis of my experience, I say distinctly: That which is decisive in the individual is not his "dynamics," but his constitution, in large measure hereditary; the *niveau* of his personality, his characteristic traits, his "tension psychologique," his spiritual form. Then, tell me that for you the problem seems resolved. And I reply: Not entirely, because if the constitution is decisive, psychodynamics remain of value. We

remain too attached to the causalist thought. We must always ask which conditions have to be fulfilled in order that the sick person may be that which he is in this moment. The psychogenic factors, psychodynamics, are always there, and they are occasionally the only ones which can be modified. But must we treat all men in distress in a psychoanalytic manner? Far from it, since only a small percentage of the ill are capable of deriving advantage from it. Only this does not dispense with those who wish to guide men to a profound knowledge of psychoanalysis and depths of human conflicts. This does not imply that they will speak about it thoughtlessly, since they will remember that there is nothing more dangerous for mental health than popularized and superficial knowledge of the doctrine of Freud.

The great paradox: we know so little and we are able to do so much.—Is it here then that what we are able to do is hardly worth the effort? It is here that the great paradox begins. Experience has taught us that the doctor, the therapist, with or without classical analysis, is able to do important work. Here we touch upon the unresolved problem of knowing what cures in psychotherapeutic treatment. No one is able to give a definite answer, no more than the question of knowing by what method and in what illnesses one achieves the best results. The common principle in all treatment is the encounter where the man feels himself accepted in love, the contact and the understanding. These are the strongest stimulants in a stagnant evolution. Out of all the uncertainties, it arises that love, understanding and communication are the most effective means, and, note well, educative factors. It is a re-education, which for the most part is none other than an education which leads to a recognition of values. The fact that it is impossible for us to indicate the way in which these means work does not alter the fact that it is a scientific certainty.

If we come back to mental health, it is necessary to say of the above-mentioned triad, that there is no way of doing great things with this in the field of mental hygiene, and that also their preventive significance remains dubious. In the importance of the findings of Spitz and Bowlby, what the ultimate outcome will be probably resides in the fact that they place the emphasis on the necessity of a warm love for the young

child, on the disastrous and irreversible results of a lack of absolute necessary factors in a vulnerable period. But knowledge of maternal deprivation ought to draw our attention toward other factors: an "educative deprivation" exists about the age of six to eight years, it exists in the "deprivation" of affectiv contact through a lifetime. Let us think, for instance, of the character distortion caused by lack of affectiv contact; let us think of the men and women without "charm."

About Education.—I would like, finally, to say a few words about education, because that is one of the topics which almost everywhere, and also among psychotherapists, has perceptibly gone down in value. "The baby is O.K.", says someone. "Don't disturb him in his development, and he'll become a normal man." This is an idea which has been passed on to us by Rousseau and which forms the foundation of many a psychotherapy, psychoanalysis, or anything else. For my part I consider it to be one of the grave mistakes. The baby is *not* "O.K."; he carries within himself all the good and bad qualities possible. He is in general—don't jump on me—more evil than the adult: he has no consideration, he is egotistical and cruel. We often find that it takes a lifetime for this "O.K. baby" in us to be conquered.

Why is it so difficult to accept the fact that we do not evolve towards an optimal creativity by ourselves? We accept with good grace that this is not the case for the creation of a work of art or for a good reproduction, that it is necessary to have an innate talent, afterwards developed. This talent may, it is true, develop in part by itself, by the penetration disposition, but cannot, for all that, dispense with educative disciplines, directives and control. The example of the teacher plays a rôle: one disciplines the talent, one works, one endeavors to conquer bad habits through unending exercises. The development of talent shows us the choice of examples, identification with the teacher, detachment from the teacher and identification with another, and so on, up to the time that the talent detaches itself from all teachers in order to become itself all-in-all, while retaining in itself something of all the others. The development of talent indicates to us the significance of communications between the ego and the world, without which the talent remains sterile. The development

of the talent shows us finally—and I have noticed it among pianists—that there are some periods where the prestation is achieved. Then, after a certain time, after some years sometimes, a change occurs: the playing of the pianist no longer is unified, the touch is less uniform, less regular, some heterogeneous elements seem to have been introduced. Others say of him, "He is falling off." He thinks of himself, "I am no longer able to do it." His playing disintegrates. But after a while, sometimes progressively, sometimes suddenly, a new progress shows itself. It is the former playing, but at a new level, broader, fuller, with new possibilities. Works which could not be interpreted in an adequate manner are now played in a masterful way. A new integration has been produced at a superior level: the disintegration was a positive disintegration which, in breaking down the old structures, created the possibility of new and broader structures. Talent is necessary, and also necessary is the inner force of development, schooling, directives, exercises and correction. It is necessary to have teachers who guard against interfering during the period of productive disintegration, who are able to remain vigilant with having an influence, and who, at the moment when the artist obtrudes, know how to efface themselves. But if one accepts all that for the artist, is it not necessary to admit it for the evolution of man, for the optimal development of all talents? For this development, it is true, it is necessary to have the disposition and the energy, but this development becomes effective only through education. The psychotherapist will do well to lend this principle all his attention.

Values.—I have treated some problems of great importance with you. I have drawn your attention to some of the terrifying uncertainties concerning the limitations of illness and health, concerning "dynamics" and depth-psychology, where there was the great problem of the directive energies of man. We talked about "human relations," education; about the fact, sometimes so little accepted, that the baby is not "O.K." But there is still a very important problem that I have not mentioned: What is the significance of supra-individual values in mental health?

At London, it has already been said that we have to declare ourselves on the matter of values. I have touched upon this

topic in speaking of the all-pervading necessity of love. It suffices perhaps, but it seems to me that it is necessary to add something, be it only to pose again the problem, in order to demonstrate in this subject the difference between mental health activities and religious groups. In an article which I always like to cite, Soddy enumerated a certain number of qualities which characterize normal man. I am only going to quote this: "his faith and his personal ideas, his system of accepted values are to him a source of spiritual power." And here is the problem: Are we in a position to help here? I believe that this is the task of education and that much has been done on this score, if, by way of example, we endeavor to live up to these values. I believe that the general humanistic values of the love of one's neighbor, justice and tolerance, are practically acceptable for anyone, no matter whom. I have more esteem for a humanist who lives up to his ideals than for a believer who does not practice them. The problem of values is, then, well and properly a problem of mental health and a problem which, like so many others, demands a solution. There is a great difference in the way the mental health worker is trying to bring man in contact with values and in the way of the priest. The first is concerned especially with that which hinders men from living according to their ideals. I do not believe that science will ever attain an understanding of that which is at the bottom of aspiration, of straining towards an ideal. But, on the other hand, I am convinced that it will penetrate more and more into the problem of that which makes man blind toward ideals, of that which presents an obstacle to their recognition.

Task and position of the Federation.—I could cite for you a great number of further problems, but my time is limited. Only, before finishing, I should like to explain myself further on some points. You have heard that to my knowledge there exists an improbable number of uncertainties. Is it that these are not of such an extent that the dissolution of the Congress and of the Federation may be desirable? May we be on the point of limiting ourselves to the "good old mental hygiene" and letting mental health go? If you believe that that was the tenor of my address, you have not understood me very well.

Certainly, the uncertainties are great and many, but it is undeniable also that there is enormous suffering. A part of

this is avoidable and useless suffering. For if suffering is an integral part of all spiritual growth, in that which is avoidable and useless, it paralyzes and exasperates. I am persuaded that much of the suffering in this world—the great tensions, and the terrifying anxieties—the self-destruction—is not inevitable given in man; that there is a means of combating and avoiding them. I am persuaded that in putting into practice the so simple principles of our mental health, in remaining objective and guarding ourselves from being carried away by too tempting devices, we are helping to prevent that. Never forget: although Spengler and Toynbee, who have tolled the death-knell of our culture, say so, it is not an absolute necessity that we are heading for another war. Our former president, Dr. William Line, clearly expressed himself in Paris: mental health is a forum; mental health begins with the "man in the street," it must interest everybody. It must be a forum of all men, who, without having renounced the ties with their country of origin (a world citizen without country is uprooted), have learned to think in an international way. The executive board and the annual meetings are a school. Through the federation I have learned much. I have learned much of misapprehensions and much of myths. To cite an example: I have the impression that at the moment the United States is, in all camps, the most misunderstood country in the world. They have, I know, given occasion for that. It is necessary for us to evaluate and propagate all we have learned that is good and estimable in the different countries. It is necessary to spread it abroad among the members of our member-associations, who do not embody less than half-a-million men. We form a network in a large part of the world. We must have confidence and courage; courage to take under consideration all intolerable situations, to attack all subjects without allowing ourselves to be turned aside for political or confessional reasons. Rarely are we capable of giving a solution, but we must learn to see and understand. We ought not to avoid subjects over which public opinion is upset, such as sexual problems, birth control, instigated abortion, homosexuality, racial discrimination, and the opinions that one formulates on all these problems. We cannot resolve them, but we ought to give them attention. Otherwise we are lost. It is necessary for us to be a forum where all may be ex-

pressed; where one can examine anything, no matter what, without seeing himself put down into a class of those held in contempt. Only under these circumstances will it be possible to be a world federation which has inscribed the "prevention of war" in its standard. Was it naïve to wish all that in 1948? Not at all! That is our duty and our task. You say to me: "You have asked yourself if we are still capable of doing that, which it may be." And I reply, all beginnings are difficult. Allow me this medical comparison: mental health finds itself in a prescientific stage, the stage in which medicine found itself in the time of Hippocrates. We already can describe some symptoms; we can see some relations, and, aided by a little empirical knowledge and a little intuition, we endeavor to treat to remedy. If the doctor had awaited scientific progress before acting, how would medicine have progressed? What would his path have been throughout two thousand years? Medicine cut a poor figure, but the art of healing was great. Let us attack the work with the means at our disposal while remembering the admirable words of the constitution of UNESCO: "Since wars begin in the minds of men, it is in the minds of men that the defense of peace must be constructed."

AGE AND SEX IN RELATION TO MENTAL DISEASE

A STUDY OF FIRST ADMISSIONS TO HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE

BENJAMIN MALZBERG, PH.D.

Director, Bureau of Statistics, New York State Department of Mental Hygiene

IT has been shown that the probability of a mental disorder, as measured by rates of first admissions to hospitals for mental disease, varies directly with age, being low in childhood and advancing to a maximum in old age.[1, 2] However, this trend is characteristic only of mental disorders as a whole. Individual groups of mental disorders appear at different ages, reach maximum rates of prevalence at different ages, and decline in incidence at varying rates. These facts are now well-established, but as pointed out in a previous study,[3] some distinguished writers of an earlier age (*i.e.* Esquirol, Rush, Earle) had very different ideas as to the relation of mental disease to age. Similar misconceptions were long held with respect to the relative prevalence of mental diseases among males and females. Esquirol, especially, perpetuated the idea that women were more liable to mental disease than men, basing this upon the fact that there are relatively more women than men in mental hospitals.[4] This was an incorrect deduction, however, since the excess of females is due primarily to their greater longevity, even in mental hospitals. Correct interpretations of the relative prevalence of mental disease in relation to age and sex can be obtained only through an enumeration of new cases developing within uniform periods. This must be done

[1] See *Social and Biological Aspects of Mental Disease*, by Benjamin Malzberg, Chapt. 2. Utica, N. Y.: State Hospitals Press, 1940.

[2] See "A Statistical Analysis of the Ages of First Admissions to Hospitals for for Mental Disease in New York State," by Benjamin Malzberg. *Psychiatric Quarterly*, Vol. 23, No. 2, April, 1949.

[3] *Ibid.*

[4] See *Mental Maladies, A Treatise on Insanity*, by E. Esquirol (Translated by E. K. Hunt, M.D.), p. 37. Philadelphia: Lea and Blanchard, 1845.

through an analysis of statistics of first admissions to mental hospitals. We shall therefore present such an analysis based upon first admissions to all hospitals for mental disease in New York State during three years ended September 30, 1951 [1] (See Table 1.)

There were 58,249 first admissions to the State and licensed hospitals for mental disease in New York State during this period, compared with 46,633 such first admissions during fiscal years 1939–1941, and 33,683 during fiscal years 1929–1931. The increase in the number of first admissions was

TABLE 1. FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1949–1951,* CLASSIFIED ACCORDING TO PRINCIPAL GROUPS OF MENTAL DISORDERS

Mental Disorders	*Number*			*Per Cent*		
	Males	Females	Total	Males	Females	Total
General paresis	842	354	1,196	2.9	1.2	2.1
Alcoholic	2,518	797	3,315	8.8	2.7	5.7
With cerebral arteriosclerosis	5,576	5,111	10,687	19.4	17.3	18.3
Senile	2,850	4,686	7,536	9.9	15.8	12.9
Involutional	1,600	3,421	5,021	5.6	11.6	8.6
Manic-depressive	830	1,635	2,465	2.9	5.5	4.2
Dementia praecox	8,300	8,517	16,817	29.0	28.8	28.9
Others	6,128	5,084	11,212	21.4	17.2	19.2
Total	28,644	29,605	58,249	100.0	100.0	100.0

* From October 1, 1948 to September 30, 1951.

accompanied by shifts in the proportionate numbers of the major groups of mental disorders. General paresis, for example, included only 1,196 of the 58,249 first admissions in 1949–1951, or 2.1 per cent of the total, compared with 9.9 per cent in 1930, and 6.1 per cent in 1940. The manic-depressive psychoses showed a similar decline. They included 13.4 per cent of the total first admissions in 1930, but only 4.2 per cent in 1950. On the other hand, first admissions with dementia praecox increased from 26.3 per cent of the total in 1930 to 28.9 per cent in 1950. The percentage with involutional psychoses increased from 2.8 to 8.6 per cent during the same interval. The most striking changes were

[1] This period was selected so as to facilitate the computation of rates of first admissions. The mid-point of this period coincided with April 1, 1950, the date of the federal census of population.

with respect to first admissions with psychoses with cerebral arteriosclerosis and senile psychoses. The former group increased from 13.4 per cent of the total first admissions in 1930 to 18.3 per cent in 1950. The latter increased from 8.8 to 12.9 per cent.

These changes were due primarily to the aging of the general population, with a corresponding increase in the proportion of first admissions aged 60 or over. In 1930, for example, the population of New York State aged 60 or over included 8.5 per cent of the total, compared with 13.1 per cent in 1950. The corresponding percentages among first admissions were 23.2 and 35.5, respectively. As a result of the increase in the average age of the general population, with corresponding changes among first admissions, the average age at first admission increased from 42.7 years in 1930 to 48.4 in 1940 to 50.3 years in 1950. The average age increased among male first admissions from 41.6 years in 1920 to 47.9 years in 1940 to 49.3 years in 1950. The average age increased among female first admissions from 43.9 in 1920 to 49.1 in 1940 to 51.4 in 1950. Thus, there has been a steady increase over several decades in the average age of first admissions to hospitals for mental disease in New York State. With but one exception, the major groups of mental disorders all showed increases in the average age at first admission between 1920 and 1950. Among general paretics, the average age increased from 43.4 to 50.3 years. Among alcoholics, the average age increased from 44.5 to 47.9 years. The average age of first admissions with psychoses with cerebral arteriosclerosis increased from 64.8 to 71.2 years. Among first admissions with senile psychoses, the average age increased from 73.6 to 78.7 years. First admissions with involutional psychoses showed an increase from an average of 53.8 to 54.1 years. First admissions with manic-depressive psychoses increased from an average age of 33.7 years to 42.0 years. Only first admissions with dementia praecox showed a decrease, the average age having decreased from 33.6 years in 1930 to 32.6 years in 1950.

The relative distributions of the several groups of mental disorders vary as one passes from the youngest to the oldest age groups. Thus, though mental disorders, as a whole, grow in relative frequency in accordance with increasing age,

TABLE 2. FIRST ADMISSIONS UNDER 15 YEARS OF AGE TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1949–1951, CLASSIFIED ACCORDING TO PRINCIPAL MENTAL DISORDERS

	Number			*Per Cent*			*Average Annual Rate per 100,000 Population*		
Mental Disorders	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	6	2	8	1.3	0.7	1.1	0.12	0.04	0.08
Alcoholic	....	....	....	....	....	....	....	....	....
With cerebral arteriosclerosis	....	....	....	....	....	....	....	....	....
Senile	....	....	....	....	....	....	....	....	....
Involutional	....	....	....	....	....	....	....	....	....
Manic-depressive	2	2	4	0.4	0.7	0.6	0.04	0.04	0.04
Dementia praecox	183	153	336	40.0	56.7	46.2	3.57	3.11	3.34
Others	266	113	379	58.2	41.9	52.1	5.18	2.29	3.77
Total	457	270	727	100.0	100.0	100.0	8.91	5.48	7.23

this trend is a compound or average of several different trends. This becomes apparent as one considers the distribution of the mental disorders in specific age groups.

We may begin by considering those under 15 years of age at time of first admission. (See Table 2.) There were 727 such first admissions, of whom 336, or 46.2 per cent, were diagnosed as dementia praecox. The majority, classified as "other," consisted primarily of behavior disorders, a group which has been increasing in number in recent years. The latter disorders are represented more frequently among males.

The number of first admissions increased rapidly in the next age group, 15 to 24 years. (See Table 3.) This age

TABLE 3. FIRST ADMISSIONS AGED 15 TO 24 YEARS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1949–1951, CLASSIFIED ACCORDING TO PRINCIPAL MENTAL DISORDERS

	Number			*Per Cent*			*Average Annual Rate per 100,000 Population*		
Mental Disorders	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	6	19	25	0.2	0.6	0.4	0.21	0.61	0.42
Alcoholic	34	19	53	0.9	0.6	0.8	1.19	0.61	0.89
With cerebral arteriosclerosis	....	....	....	....	....	....	....	....	....
Senile	....	....	....	....	....	....	....	....	....
Involutional	....	....	....	....	....	....	....	....	....
Manic-depressive	75	173	248	2.0	5.8	3.7	2.62	5.57	4.16
Dementia praecox	2,569	1,862	4,431	68.7	62.4	65.9	89.73	60.00	74.26
Others	1,053	910	1,963	28.2	30.5	29.2	36.78	39.32	32.90
Total	3,737	2,983	6,720	100.0	100.0	100.0	130.53	96.12	112.63

interval included 6,720 cases, of whom 4,431, or almost two-thirds, represented dementia praecox. There were 248 first admissions with manic-depressive psychoses, or 3.7 per cent of the total in this age group. There were a few cases of general paresis and alcoholic psychoses.

Dementia praecox continued as the outstanding category at ages 25 to 34. (See Table 4.) Of a total of 9,404 first admissions in this age group, 5,834, or 62.0 per cent, were so diagnosed. The manic-depressive psychoses showed a slight relative increase in this age group. The alcoholic psychoses

TABLE 4. FIRST ADMISSIONS AGED 25 TO 34 YEARS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1949–1951, CLASSIFIED ACCORDING TO PRINCIPAL MENTAL DISORDERS

	Number			*Per Cent*			*Average Annual Rate per 100,000 Population*		
Mental Disorders	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	49	38	87	1.1	0.8	0.9	1.44	1.01	1.22
Alcoholic	265	120	385	5.7	2.5	4.1	7.82	3.20	5.39
With cerebral arteriosclerosis	....	....	....	....	....	....	....	....	....
Senile	....	....	....	....	....	....	....	....	....
Involutional	....	11	11	....	0.2	0.1	....	0.29	0.15
Manic-depressive ...	137	415	552	3.0	8.7	5.9	4.04	11.06	7.73
Dementia praecox ..	2,879	2,955	5,834	62.0	62.1	62.0	84.96	78.76	81.70
Others	1,314	1,221	2,535	28.3	25.7	27.0	38.78	32.54	35.50
Total	4,644	4,760	9,404	100.0	100.0	100.0	137.04	126.87	131.70

increased significantly to a total of 385 first admissions, or 4.1 per cent of the total. It will be noted that dementia praecox is relatively more prevalent among males than among females at ages under 35 years. Whether this is due to social selection with respect to hospitalization, or to intrinsic biological factors is still a moot question.

Significant differences began to appear in the age group 35 to 44 years. (See Table 5.) Dementia praecox was still the outstanding category, including 3,855 of the first admissions, but this represented only 43.8 per cent of the total. The manic-depressive group increased to 725, or 8.2 per cent of the total. The alcoholic psychoses included 927 first admissions, or 10.5 per cent of the total, the largest in this age group, next to dementia praecox. The involutional psychoses

TABLE 5. FIRST ADMISSIONS AGED 35 TO 44 YEARS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO PRINCIPAL MENTAL DISORDERS

	Number			*Per Cent*			*Average Annual Rate per 100,000 Population*		
Mental Disorders	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	195	101	296	4.8	2.2	3.4	5.82	2.79	4.24
Alcoholic	660	267	927	16.1	5.7	10.5	19.71	7.38	13.31
With cerebral arteriosclerosis ...	9	14	23	0.2	0.3	0.3	0.27	0.39	0.33
Senile	....	....	....	....	....	....	....	....	....
Involutional	63	444	507	1.5	9.4	5.8	1.88	12.27	7.28
Manic-depressive ..	221	504	725	5.4	10.7	8.2	6.60	13.93	10.41
Dementia praecox ..	1,686	2,169	3,855	41.1	46.2	43.8	50.35	60.00	55.34
Others	1,267	1,199	2,466	30.9	25.5	28.0	37.84	33.14	35.40
Total	4,101	4,698	8,799	100.0	100.0	100.0	122.47	129.88	126.32

also entered into the picture with 507 first admissions, or 5.8 per cent of the total. Sex differences became apparent, with a relative excess of males with general paresis and alcoholic psychoses. On the other hand, there was a great excess of females in connection with involutional psychoses and manic-depressive psychoses. The relative excess of females with dementia praecox is also significant, beginning with this age group.

In the age group 45 to 54 years, (see Table 6), there were 1,636 first admissions with dementia praecox, representing

TABLE 6. FIRST ADMISSIONS AGED 45 TO 54 YEARS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO PRINCIPAL MENTAL DISORDERS

	Number			*Per Cent*			*Average Annual Rate per 100,000 Population*		
Mental Disorders	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	256	87	343	6.5	2.1	4.2	8.53	2.85	5.67
Alcoholic	816	219	1,035	20.8	5.2	12.8	27.20	7.19	17.11
With cerebral arteriosclerosis ...	181	138	319	4.6	3.3	3.9	6.03	4.53	5.27
Senile	2	6	8	0.1	0.1	0.1	0.07	0.20	0.13
Involutional	630	1,672	2,302	16.1	40.0	28.4	21.00	54.86	38.07
Manic-depressive ...	219	274	493	5.6	6.6	6.1	7.30	8.99	8.15
Dementia praecox ..	697	939	1,636	17.8	22.4	20.2	23.24	30.81	27.05
Others	1,121	844	1,965	28.6	20.2	24.3	37.37	27.69	32.49
Total	3,922	4,179	8,101	100.0	100.0	100.0	130.76	137.11	133.96

only 20.2 per cent of the total, or less than half of the percentage in the preceding age group. The manic-depressive psychoses also decreased in relative prevalence. On the other hand, the involutional psychoses constituted the largest category in this age group, including 2,302 first admissions, or 28.4 per cent of the total. The alcoholic psychoses reached a peak, including 1,035 first admissions, or 12.8 per cent of the total. Psychoses with cerebral arteriosclerosis reached the first significant total, there being 319 such first admissions in

TABLE 7. FIRST ADMISSIONS AGED 55 TO 64 YEARS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO PRINCIPAL MENTAL DISORDERS

	Number			*Per Cent*			*Average Annual Rate per 100,000 Population*		
Mental Disorders	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	223	63	286	5.6	1.8	3.8	9.83	2.78	6.30
Alcoholic	553	136	689	14.0	3.8	9.1	24.37	5.99	15.18
With cerebral arteriosclerosis	1,202	1,045	2,247	30.4	29.0	29.8	52.96	46.04	49.50
Senile	107	146	253	2.7	4.1	3.4	4.71	6.43	5.57
Involutional	736	1,124	1,860	18.6	31.2	24.6	32.43	49.52	40.98
Manic-depressive	120	194	314	3.0	5.4	4.2	5.29	8.54	6.92
Dementia praecox	242	349	591	6.1	9.7	7.8	10.66	15.38	13.02
Others	768	541	1,309	19.5	15.0	17.3	33.84	23.84	28.84
Total	3,951	3,598	7,549	100.0	100.0	100.0	174.08	158.52	166.30

this age group, or 3.9 per cent of the total. The sex differences were similar to those of the preceding age group.

In the age group 55 to 64 years, (see Table 7), dementia praecox included only 591 first admissions, or 7.8 per cent of the total, compared with 1,629, or 20.1 per cent in the preceding age group. Psychoses with cerebral arteriosclerosis exceeded all other categories with a total of 2,247, or 29.8 per cent of the total. The involutional psychoses ranked high in this age group, with 1,860 first admissions, or 24.6 per cent of the total. However, this represented an absolute decrease in comparison with the preceding age interval. General paresis and the alcoholic psychoses both showed relative decreases in this age group.

As we enter the older age intervals, all of the groups of mental disorders lose numerical importance, except the two associated with advanced age. First admissions with cerebral

TABLE 8. FIRST ADMISSIONS AGED 65 TO 74 YEARS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO PRINCIPAL MENTAL DISORDERS

Mental Disorders	Number			Per Cent			Average Annual Rate per 100,000 Population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	84	35	119	2.1	0.9	1.5	6.77	2.49	4.49
Alcoholic	169	29	198	4.3	0.7	2.5	13.63	2.06	7.48
With cerebral arteriosclerosis ...	2,346	2,109	4,455	60.0	53.3	56.6	189.16	149.85	168.26
Senile	796	1,277	2,073	20.3	32.3	26.3	64.18	90.73	78.30
Involutional	167	165	332	4.3	4.2	4.2	13.47	11.72	12.54
Manic-depressive ...	50	67	117	1.3	1.7	1.5	4.03	4.76	4.42
Dementia praecox ..	34	71	105	0.9	1.8	1.3	2.74	5.04	3.97
Others	266	206	472	6.8	5.2	6.0	21.44	14.64	17.83
Total	3,912	3,959	7,871	100.0	100.0	100.0	315.43	281.30	297.29

arteriosclerosis included 4,455 first admissions in the age group 65 to 74 years, or 56.6 per cent of the total. (See Table 8.) The senile psychoses grew to a total of 2,073 first admissions, or 26.3 per cent.

In the highest age group, those aged 75 or over, this contrast became even more marked. (See Table 9.) First admissions with psychoses with cerebral arteriosclerosis included 3,631 cases, or 40.2 per cent of the total, and the senile psychoses included 5,191, or 57.4 per cent. Together, these two

TABLE 9. FIRST ADMISSIONS AGED 75 YEARS OR OVER TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO PRINCIPAL MENTAL DISORDERS

Mental Disorders	Number			Per Cent			Average Annual Rate per 100,000 Population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	22	7	29	0.6	0.1	0.3	4.60	1.08	2.57
Alcoholic	19	4	23	0.4	0.1	0.3	3.97	0.62	2.04
With cerebral arteriosclerosis ...	1,833	1,798	3,631	47.0	35.1	40.2	382.86	277.05	321.97
Senile	1,944	3,247	5,191	49.8	63.4	57.4	406.04	500.33	460.30
Involutional	4	5	9	0.1	0.1	0.1	0.84	0.77	0.80
Manic-depressive ...	6	6	12	0.2	0.1	0.1	1.25	0.92	1.06
Dementia praecox ..	5	12	17	0.1	0.2	0.2	1.04	1.84	1.51
Others	70	46	116	1.8	0.9	1.3	14.62	7.09	10.29
Total	3,903	5,125	9,028	100.0	100.0	100.0	815.22	789.70	800.54

categories included 97.6 per cent of the first admissions in this age group.

From the preceding summaries, it is clear that as the age categories change, there are corresponding changes in the relative distribution of the groups of mental disorders. Admissions are few at the youngest ages, but these are predominantly cases of dementia praecox and the behavior disorders. In the very youngest age group among males, the behavior disorders are almost as frequent as dementia praecox. Dementia praecox is the most frequent category of mental disease among both males and females through ages 35 to 44. In the latter group, however, alcoholic psychoses rise to a significant proportion among males, and manic-depressive psychoses assume a leading position among females. As we pass age 45, dementia praecox loses its relative numerical importance. Between ages 45 to 54, it is replaced among males by alcoholic psychoses, and among females by involutional psychoses. After age 55, the leading categories among males are psychoses with cerebral arteriosclerosis and senile psychoses. Among females, the leading categories at ages 55 to 64 consist of involutional psychoses and psychoses with cerebral arteriosclerosis, but at the oldest ages the senile psychoses predominate.

We shall consider next how rates of first admission vary with respect to age in the several groups of mental disorders.

All First Admissions—There were 58,249 first admissions during the period of three years which ended September 30, 1951, of whom 28,644, or 49.2 per cent, were males and 29,605, or 50.8 per cent, were females. The sex ratio has been changing for several decades. In 1930, males constituted 55 per cent of the total first admissions. The change is related, in part, to a decrease in the sex ratio of the general population of New York State. In 1930, males represented 50.1 per cent of the total population, compared with 48.8 per cent in 1950. The average age at first admission was 50.3 years. Males and females had average ages of 49.3 and 51.4 years, respectively.

The age distribution of the first admissions is shown in Table 10. There were few cases under 10 years of age, most of these being behavior disorders. Compared with previous years, there was a relatively large total aged 10 to 14 years,

TABLE 10. FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1949–1951, AND AVERAGE ANNUAL RATE PER 100,000 POPULATION, CLASSIFIED ACCORDING TO AGE

Age (Years)	Number			Per Cent			Average Annual Rate per 100,000 Population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10....	145	27	172	0.5	0.1	0.3	3.85	0.74	2.33
10–14	312	243	555	1.1	0.8	1.0	22.81	18.56	20.74
15–19	1,239	1,152	2,391	4.3	3.8	4.1	93.22	83.30	88.16
20–24	2,498	1,831	4,329	8.7	6.2	7.4	162.85	106.42	133.02
25–29	2,585	2,365	4,950	9.0	8.0	8.5	150.12	124.55	136.71
30–34	2,059	2,395	4,454	7.2	8.1	7.6	123.54	129.24	126.54
35–39	2,027	2,460	4,487	7.1	8.3	7.7	119.78	131.02	125.70
40–44	2,074	2,238	4,312	7.2	7.5	7.4	125.22	128.65	126.98
45–49	1,924	2,148	4,072	6.7	7.3	7.0	125.21	137.24	131.28
50–54	1,998	2,031	4,029	7.0	6.9	6.9	136.58	136.98	136.78
55–59	1,921	1,857	3,778	6.7	6.3	6.4	154.38	149.64	152.02
60–64	2,030	1,741	3,771	7.1	5.9	6.4	197.99	169.23	183.59
65–69	1,993	1,831	3,824	7.0	6.2	6.6	263.98	219.20	240.46
70–74	1,919	2,128	4,047	6.7	7.2	7.0	395.47	371.98	382.76
75–84	3,042	3,862	6,904	10.6	13.0	11.9	731.94	707.94	718.32
85 or over....	861	1,263	2,124	3.0	4.3	3.6	1,363.23	1,220.79	1,274.78
Unascertained	17	33	50	0.1	0.1	0.1	.....	.....	.....
Total	28,644	29,605	58,249	100.0	100.0	100.0	131.88	130.01	130.92

most of these being cases of dementia praecox. Beginning with age group 15 to 19, there was a rapid increase, the average annual rate being 88.2 per 100,000 population. The rate increased to 136.7 per 100,000 population at ages 25 to 29, but decreased thereafter to a rate of 125.7 per 100,000 at ages 35 to 39. From age 40 on, there was a steady increase to a maximum rate of 1,274.8 at ages 85 or over.

In the case of the males, the rate rose rapidly at ages 20 to 29 years, owing probably to an unusual increase of first admissions with dementia praecox at these ages. The rate then fell to 125.2 at ages 45 to 49, followed thereafter by a steady increase to a maximum of 1,363.2 per 100,000 population at ages 85 or over. In the case of the females, the rates rose fairly uniformly to a maximum of 1,220.8 per 100,000 population. In general, the rates for males exceeded those for females, except in the range from 30 to 54 years of age. It is probable that the higher rates for females in these age groups is associated with the sex difference in the involutional psychoses.

Table 11 compares the average annual rates of first admissions at corresponding ages from 1920 to 1950. The rates in 1930 among males were, with only two exceptions, higher than those in 1920. A decade later, the average annual rates exceeded those of 1930 in all but one age group. In 1950, there were large and significant increases in the average annual rates under 30 years of age, and also at ages 70 or over. In the intermediate age groups, the average annual

TABLE 11. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 POPULATION, 1919–1921, 1929–1931, 1939–1941, AND 1949–1951

Males

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
15–19	54.01	57.80	60.06	93.22	1.07	1.04	1.55	1.73
20–24	108.74	100.72	103.96	162.85	0.93	1.03	1.57	1.49
25–29	120.64	103.00	111.22	150.12	0.85	1.08	1.34	1.24
30–34	114.49	124.52	124.89	123.54	1.09	1.00	0.99	1.08
35–39	120.77	143.12	134.20	119.78	1.19	0.94	0.89	0.99
40–44	113.10	136.13	140.31	125.22	1.20	1.03	0.89	1.11
45–49	108.14	134.47	144.67	125.21	1.24	1.08	0.87	1.16
50–54	106.04	149.25	164.58	136.58	1.41	1.10	0.83	1.29
55–59	118.32	150.27	172.61	154.38	1.27	1.14	0.89	1.30
60–64	139.66	180.48	213.46	197.99	1.29	1.18	0.93	1.42
65–69	178.57	220.34	282.50	263.98	1.23	1.28	0.93	1.48
70–74	190.08	316.75	375.02	395.47	1.68	1.18	1.05	2.08
75 or over....	289.00	465.56	679.26	815.22	1.61	1.46	1.20	2.82

Females

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
15–19	40.36	38.68	50.51	83.30	0.96	1.31	1.64	2.06
20–24	66.67	67.53	80.56	106.42	1.01	1.19	1.32	1.60
25–29	95.62	84.86	102.91	124.55	0.89	1.21	1.21	1.30
30–34	100.51	97.09	110.69	129.24	0.97	1.14	1.17	1.29
35–39	106.74	102.15	121.01	131.02	0.96	1.18	1.08	1.23
40–44	107.97	114.26	116.06	128.65	1.06	1.02	1.11	1.19
45–49	121.88	107.59	132.86	137.24	0.88	0.94	1.03	1.13
50–54	125.56	119.39	145.39	136.98	0.95	1.22	0.94	1.09
55–59	120.79	121.52	149.32	149.64	1.01	1.23	1.00	1.24
60–64	134.01	134.76	179.66	169.33	1.01	1.33	0.94	1.26
65–69	149.04	170.26	240.27	219.20	1.18	1.36	0.91	1.47
70–74	208.37	228.54	319.00	371.98	1.10	1.40	1.17	1.79
75 or over....	282.37	376.92	603.30	789.70	1.33	1.60	1.31	2.80

rates decreased by from 7 to 13 per cent. Compared with 1920, the male rates, with one exception, all showed significant increases over a period of 30 years.

In the case of the females, the average annual rates were lower at the younger age levels in 1930 than in 1920, but higher at the older ages. Between 1930 and 1940, there were large and significant increases at practically all ages. Between 1940 and 1950, the rates increased significantly until age 45, remaining fairly constant through ages 65 to 69, and increased at ages 70 or over. Over the entire period of 30 years from 1920 to 1950, the average annual rate of first admissions increased significantly in every age interval.

General Paresis.—There were 1,196 first admissions with general paresis, of whom 842, or 70.4 per cent, were males, and 354, or 29.6 per cent, females. (See Table 12.) The average age at first admission was 50.3 years. Males and females had average ages of 51.4 and 47.4, respectively. The age groups 40 to 59 included 58 per cent of the total first admissions with general paresis. There was a significant sex difference, 30 per cent of the female paretics being under 40 years of age at time of first admission, compared with 15 per

TABLE 12. FIRST ADMISSIONS WITH GENERAL PARESIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, OCTOBER 1, 1948 TO SEPTEMBER 30, 1951, INCLUSIVE, AND AVERAGE ANNUAL RATE PER 100,000 POPULATION

Age (Years)	Number			Per Cent			Average Annual Rate per 100,000 Population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 15	6	2	8	0.7	0.6	0.7	0.12	0.04	0.08
15–19	....	9	9	....	2.5	0.8	....	0.65	0.33
20–24	6	10	16	0.7	2.8	1.3	0.39	0.58	0.49
25–29	19	14	33	2.3	4.0	2.8	1.10	0.74	0.91
30–34	30	24	54	3.6	6.8	4.5	1.80	1.30	1.53
35–39	68	50	118	8.1	14.1	9.9	4.02	2.66	3.31
40–44	127	51	178	15.1	14.4	14.9	7.67	2.93	5.24
45–49	130	44	174	15.4	12.4	14.5	8.46	2.81	5.61
50–54	126	43	169	15.0	12.1	14.1	8.61	2.90	5.74
55–59	135	39	174	16.0	11.0	14.5	10.85	3.14	7.00
60–64	88	24	112	10.4	6.8	9.4	8.58	2.33	5.45
65–69	58	23	81	6.9	6.5	6.8	7.68	2.75	5.09
70–74	26	12	38	3.1	3.4	3.2	5.36	2.10	3.59
75 or over....	22	7	29	2.6	2.0	2.4	4.60	1.08	2.57
Unascertained	1	2	3	0.1	0.6	0.3	....	....	....
Total	842	354	1,196	100.0	100.0	100.0	3.88	1.55	2.69

cent of the males. It is probable that females are infected with syphilis at a younger age than males.

The average annual rate of first admissions with general paresis rose to a maximum at ages 55 to 59. (See Table 13.) Each sex showed a similar trend, with a maximum at ages 55 to 59. The male rates were in significant excess over those for females at every age.

TABLE 13. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH GENERAL PARESIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 POPULATION, 1919–1921, 1929–1931, 1939–1941, AND 1949–1951

Males

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
15–19	0.42	0.44	0.53	....	1.04	1.20	....	....
20–24	1.30	1.21	0.54	0.39	0.93	0.44	0.72	0.30
25–29	6.49	5.68	3.48	1.10	0.88	0.61	0.32	0.17
30–34	20.80	18.19	12.10	1.80	0.87	0.67	0.14	0.09
35–39	39.36	28.57	19.37	4.02	0.73	0.68	0.21	0.10
40–44	45.20	34.12	23.52	7.67	0.75	0.69	0.33	0.17
45–49	42.49	34.03	24.85	8.46	0.80	0.73	0.34	0.20
50–54	35.59	33.43	25.09	8.61	0.94	0.75	0.34	0.24
55–59	28.09	23.59	20.12	10.85	0.84	0.85	0.54	0.39
60–64	23.42	19.33	16.41	8.58	0.83	0.84	0.52	0.37
65–69	10.79	12.99	15.26	7.68	1.20	1.17	0.50	0.71
70–74	1.54	5.76	8.90	5.36	3.74	1.54	0.60	3.48
75 or over....	1.05	5.14	6.78	4.60	4.90	1.32	0.68	4.38

Females

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
15–19	0.48	0.49	0.89	0.65	1.02	1.82	0.73	1.35
20–24	1.29	0.85	0.73	0.58	0.66	0.86	0.79	0.45
25–29	2.83	2.41	2.44	0.74	0.85	1.01	0.30	0.26
30–34	5.47	4.04	4.78	1.30	0.74	1.18	0.27	0.24
35–39	7.88	7.52	6.73	2.66	0.95	0.89	0.40	0.34
40–44	9.13	8.61	6.99	2.93	0.94	0.81	0.42	0.32
45–49	8.97	8.06	6.51	2.81	0.90	0.81	0.43	0.31
50–54	7.93	8.15	6.14	2.90	0.78	0.76	0.47	0.37
55–59	4.32	5.71	5.85	3.14	1.32	1.02	0.54	0.73
60–64	1.48	3.72	5.68	2.33	2.51	1.53	0.41	1.57
65–69	0.62	3.53	3.54	2.75	5.69	1.00	0.78	4.44
70–74	....	0.98	2.33	2.10	....	2.38	0.90	....
75 or over....	....	1.00	1.82	1.08	....	1.82	0.59	....

Contrary to the trends shown for all first admissions, the average annual rates of first admissions with general paresis have been decreasing steadily. Except for some random fluctuations in the groups with advanced age (where the rates are relatively low), the rates for each decade show decreases in comparison with the previous decade. Between 1920 and 1950, these decreases varied from 60 to 90 per cent.

Alcoholic Psychoses.—There were 3,315 first admissions with alcoholic psychoses, of whom 2,518, or 76.0 per cent, were

TABLE 14. FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, OCTOBER 1, 1948 TO SEPTEMBER 30, 1951, INCLUSIVE, AND AVERAGE ANNUAL RATE PER 100,000 POPULATION

Age (*Years*)	*Number*			*Per Cent*			*Average Annual Rate per 100,000 Population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 15.....	....	....	....	....	....	....	....	....	....
15–19	3	2	5	0.1	0.3	0.2	0.23	0.14	0.18
20–24	31	17	48	1.2	2.1	1.4	2.02	0.99	1.47
25–29	98	45	143	3.9	5.6	4.3	5.69	2.37	3.95
30–34	167	75	242	6.6	9.4	7.3	10.02	4.05	6.88
35–39	264	111	375	10.5	13.9	11.3	15.60	5.91	10.50
40–44	396	156	552	15.7	19.6	16.7	23.91	8.97	16.26
45–49	427	130	557	17.0	16.3	16.8	27.79	8.31	17.96
50–54	389	89	478	15.4	11.2	14.4	26.59	6.00	16.23
55–59	322	81	403	12.8	10.2	12.2	25.88	6.53	16.22
60–64	231	55	286	9.2	6.9	8.6	22.53	5.35	13.92
65–69	137	22	159	5.4	2.8	4.8	18.15	2.63	10.00
70–74	32	7	39	1.3	0.9	1.2	6.59	1.22	3.69
75 or over...	19	4	23	0.8	0.5	0.7	3.97	0.62	2.04
Unascertained	2	3	5	0.1	0.3	0.2	....	....	....
Total	2,518	797	3,315	100.0	100.0	100.0	11.59	3.50	7.45

males, and 797, or 24.0 per cent, females. (See Table 14.) The average age at first admission was 47.9 years. Males were older than females, their average ages at first admission being 48.6 and 45.4 years, respectively. The great majority of the admissions were between 35 and 59 years of age. Females included relatively more under 35 years of age, and relatively fewer aged 60 or over. There is a tendency for females to begin excessive drinking at younger ages than males.

The average annual rate per 100,000 population rose to a maximum of 18.0 at ages 45 to 49, and decreased beyond that

age. (See Table 15.) The rate rose to a maximum of 27.8 per 100,000 males aged 45 to 49, but reached a maximum of only 9.0 among females at ages 40 to 44. The rates for males were greatly in excess of the rates for females in all corresponding age groups.

The average annual rates of first admissions among males with alcoholic psychoses in 1930 exceeded those in 1920 at every age. With only one exception, the rates increased during this decade by more than 100 per cent. The average

TABLE 15. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 POPULATION, 1919–1921, 1929–1931, 1939–1941, 1949–1951

Males

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
20–24	0.77	1.58	1.39	2.02	2.05	0.88	1.45	2.62
25–29	2.72	5.13	6.60	5.69	1.89	1.29	0.86	2.09
30–34	4.70	11.29	15.49	10.02	2.40	1.37	0.66	2.13
35–39	7.37	18.13	24.14	15.60	2.46	1.33	0.84	2.12
40–44	8.59	21.36	27.37	23.91	2.49	1.28	0.87	2.78
45–49	8.83	22.50	29.37	27.79	2.54	1.31	0.94	3.14
50–54	8.99	19.22	28.89	26.59	2.14	1.50	0.92	2.96
55–59	9.02	20.54	23.63	25.88	2.28	1.15	1.10	2.87
60–64	7.45	16.80	21.58	22.53	2.26	1.28	1.04	3.02
65–69	3.60	14.17	17.39	18.15	3.94	1.23	1.04	5.04
70–74	1.03	4.32	6.48	6.59	4.19	1.50	1.02	6.40
75 or over....	0.53	5.14	2.95	3.97	9.70	0.57	1.34	7.49

Females

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
20–24	0.07	0.46	0.51	0.99	6.57	1.11	1.94	14.14
25–29	0.54	0.76	2.27	2.37	1.41	2.99	1.04	4.39
30–34	1.44	1.92	4.28	4.05	1.33	2.23	0.94	2.81
35–39	2.38	3.51	4.94	5.91	1.47	1.41	1.20	2.48
40–44	1.74	5.59	5.04	8.97	3.21	0.90	1.78	5.16
45–49	3.92	4.52	4.83	8.31	1.15	1.07	1.72	2.12
50–54	2.91	3.33	5.89	6.00	1.14	1.77	1.02	2.06
55–59	1.90	3.59	5.12	6.53	1.89	1.43	1.28	3.44
60–64	1.48	2.59	4.92	5.35	1.75	1.90	1.09	3.61
65–69	1.24	0.22	2.41	2.63	0.18	1.10	1.09	2.12
70–74	0.45	0.98	1.63	1.22	2.18	1.66	0.74	2.71
75 or over....	0.41	....	0.91	0.62	....	....	0.68	1.51

annual rates in 1940 exceeded those of 1930, but by much smaller amounts. In 1950, however, the annual rates of first admissions were less than those in 1940 through the age interval 50 to 54, but they were in excess at ages 55 or over. If we compare 1950 with 1920, we find increases in every age interval by amounts varying from 100 to 200 per cent up to ages 60 to 64, and by even greater amounts after that age.

In the case of the females, there were similar increases

TABLE 16. FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, OCTOBER 1, 1948 TO SEPTEMBER 30, 1951, INCLUSIVE, AND AVERAGE ANNUAL RATE PER 100,000 POPULATION

Age (Years)	Number			Per Cent			Average Annual Rate per 100,000 Population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
35–39	....	1	1	....	*	*	....	0.05	0.03
40–44	9	13	22	0.2	0.3	0.2	0.54	0.75	0.65
45–49	25	35	60	0.4	0.7	0.6	1.63	2.24	1.93
50–54	156	103	259	2.8	2.0	2.4	10.66	6.95	8.79
55–59	355	330	685	6.4	6.4	6.4	28.53	26.59	27.56
60–64	847	715	1,562	15.2	14.0	14.6	82.61	69.50	76.04
65–69	1,187	1,021	2,208	21.3	20.0	20.7	157.22	122.23	138.84
70–74	1,159	1,088	2,247	20.8	21.3	21.0	238.85	190.19	212.52
75–79	958	904	1,862	17.2	17.7	17.4	343.94	256.07	294.82
80–84	578	579	1,157	10.4	11.3	10.8	420.80	300.18	350.35
85 or over	297	315	612	5.3	6.2	5.7	470.24	304.47	367.31
Unascertained	5	7	12	0.1	0.1	0.1	....	....	....
Total	5,576	5,111	10,687	100.0	100.0	100.0	25.67	22.44	24.02

* Less than 0.05.

in the rate of first admissions in each age group between 1920 and 1930, and between 1930 and 1940. Contrary to the experience of males, the rates for females in 1950 were in excess of those for 1940 in almost all age intervals. As in the case of the males, there were exceedingly high rates of increase between 1920 and 1950.

Cerebral Arteriosclerosis.—There were 10,687 first admissions with psychoses with cerebral arteriosclerosis during the three years ended September 30, 1951, of whom, 5,576, or 52.2 per cent, were males, and 5,110, or 47.8 per cent, females. (See Table 16.) The average age was 71.2 years. Females were slightly older than males, the average ages being 71.4 and 71.0, respectively. There were relatively few first admissions

under 60 years of age. At ages 60 to 64, the average annual rate was 76.0 per 100,000 population. The rate increased steadily thereafter to a maximum of 367.3 at ages 85 or over. Males and females showed similar trends, though rates for the former were higher at every age. The male rate reached a maximum of 470.2 at 85 years or over, compared with 304.4 among females.

Between 1920 and 1930, the average annual rates of first admissions with psychoses with cerebral arteriosclerosis increased among males at every age. (See Table 17.) The rates of increase were especially large at ages 70 or over. The rates increased again between 1930 and 1940, though less rapidly than during the preceding decade. Between 1940 and 1950, however, the rates decreased significantly at all ages under 70. In comparison with 1920, there were increases dur-

TABLE 17. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 POPULATION, 1919–1921, 1929–1931, 1939–1941, 1949–1951

Males

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
40–44	0.74	1.80	1.18	0.54	2.43	0.66	0.46	0.73
45–49	2.08	4.23	3.75	1.63	2.03	0.89	0.43	0.78
50–54	9.36	16.32	23.03	10.66	1.74	1.41	0.46	1.14
55–59	21.28	41.74	53.56	28.53	1.96	1.28	0.53	1.34
60–64	42.79	75.96	107.12	82.61	1.78	1.41	0.77	1.93
65–69	72.61	111.23	174.08	157.22	1.53	1.56	0.90	2.17
70–74	57.70	157.66	218.54	238.85	2.73	1.39	1.09	4.14
75 or over....	62.64	195.48	287.74	382.65	3.12	1.47	1.33	6.11

Females

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
40–44	1.07	2.80	1.26	0.75	2.62	0.45	0.62	0.70
45–49	3.14	6.11	5.32	2.24	1.94	0.87	0.42	0.71
50–54	7.42	15.11	17.18	6.95	2.04	1.14	0.40	0.94
55–59	21.26	34.53	44.59	26.59	1.62	1.29	0.60	1.25
60–64	30.23	52.19	89.58	69.50	1.73	1.72	0.78	2.30
65–69	31.67	76.89	134.13	122.23	2.43	1.74	0.91	3.86
70–74	33.68	86.92	160.17	190.19	2.58	1.84	1.19	5.64
75 or over....	38.15	111.51	200.95	276.90	2.92	1.80	1.38	7.26

ing the thirty years in amounts varying from 14 to over 500 per cent.

The trends were very similar for the females. Rates of first admissions with psychoses with cerebral arteriosclerosis increased significantly between 1920 and 1930. Between 1930 and 1940, the rates decreased among those aged less than 50 years, but increased in all age intervals above 50, though the percentage increases were not as great as during the preceding decade. Between 1940 and 1950 the rates decreased significantly below age 70, but increased beyond that age. During the three decades between 1920 and 1950, the rates increased significantly, beginning with age group 55–59.

Senile Psychoses.—There were 7,536 first admissions with senile psychoses during the three years ended September 30, 1951. Of this total, 2,850, or 37.8 per cent, were males, and 4,686, or 62.2 per cent, were females. The average age at first admission was 78.7 years. The females were slightly but significantly older than the males, their average ages being 78.8 and 78.4, respectively. (See Table 18.)

The average annual rate of first admissions was only 0.3 per 100,000 population aged 50 to 54 years. The rate increased with advancing age, reaching a maximum of 895.4 at 85 or over. Males and females showed similar trends, but the rates for the latter were significantly in excess in all corresponding age groups.

TABLE 18. FIRST ADMISSIONS WITH SENILE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, OCTOBER 1, 1948 TO SEPTEMBER 30, 1951, INCLUSIVE, AND AVERAGE ANNUAL RATE PER 100,000 POPULATION

Age (Years)	*Number*			*Per cent*			*Average Annual Rate per 100,000 Population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
50–54	2	6	8	0.1	0.1	0.1	0.14	0.40	0.27
55–59	9	19	28	0.3	0.4	0.4	0.72	1.53	1.13
60–64	98	127	225	3.4	2.7	3.0	9.56	12.34	10.95
65–69	249	392	641	8.7	8.4	8.5	33.31	46.93	40.31
70–74	547	885	1,432	19.2	18.9	19.0	112.73	154.70	135.44
75–79	731	1,119	1,850	25.6	23.9	24.5	262.71	317.61	293.40
80–84	659	1,189	1,848	23.1	25.4	24.5	479.77	616.43	559.59
85 or over...	554	939	1,493	19.4	20.0	19.8	877.15	906.65	895.47
Unascertained	1	10	11	*	0.2	0.1	....	....	....
Total	2,850	4,686	7,536	100.0	100.0	100.0	13.12	20.58	16.94

* Less than 0.05.

Rates of first admissions with senile psychoses decreased among males throughout the 30 years from 1920 to 1950 at all ages under 75. (See Table 19.) The rate increased significantly after age 75. It should be noted that 70 per cent of the first admissions with senile psychoses are aged 75 or over. The results were very similar for females. The rates decreased steadily among those under 70 years of age. At ages 70 to 74 they decreased between 1920 and 1930, but

TABLE 19. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH SENILE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 POPULATION, 1919–1921, 1929–1931, 1939–1941, 1949–1951

Males

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
50–54	0.99	0.60	0.61	0.14	0.61	1.01	0.23	0.14
55–59	3.58	1.97	1.72	0.72	0.55	0.87	0.42	0.20
60–64	18.10	16.30	12.02	9.56	0.90	0.74	0.80	0.53
65–69	48.40	46.29	33.54	33.31	0.96	0.72	0.99	0.69
70–74	117.45	114.46	113.85	112.73	0.97	0.99	0.99	0.96
75 or over...	206.87	243.50	361.94	406.04	1.18	1.49	1.12	1.96

Females

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
50–54	2.43	2.08	1.47	0.40	0.86	0.71	0.27	0.16
55–59	5.01	4.52	3.03	1.53	0.90	0.67	0.50	0.31
60–64	32.76	26.98	18.67	12.34	0.82	0.69	0.66	0.38
65–69	72.03	62.79	53.71	46.93	0.87	0.86	0.87	0.65
70–74	154.48	125.34	130.12	154.70	0.81	1.04	1.19	1.00
75 or over...	224.78	263.41	382.07	500.30	1.17	1.47	1.29	2.23

increased between 1930 and 1950. The increases were very large and significant among those aged 75 or over.

Involutional Psychoses.—There were 5,021 first admissions with involutional psychoses during the three years ended September 30, 1951, of whom 1,600, or 31.9 per cent were males, and 3,421, or 68.1 per cent, were females. (See Table 20.) These admissions occurred at an average age of 54.1 years. Males were older than females, the average ages being 56.4 and 53.0 years, respectively. Fifty per cent of the cases were admitted at ages 50 to 59.

TABLE 20. FIRST ADMISSIONS WITH INVOLUTIONAL PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1949–1951, AND AVERAGE ANNUAL RATE PER 100,000 POPULATION, CLASSIFIED ACCORDING TO AGE

Age (Years)	Number			Per Cent			Average Annual Rate per 100,000 Population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
25–29	....	....	....	....	....	....	....	....	....
30–34	....	11	11	....	0.3	0.2	....	0.59	0.31
35–39	5	64	69	0.3	1.9	1.4	0.30	3.41	1.93
40–44	58	380	438	3.6	11.1	8.7	3.50	21.84	12.90
45–49	223	759	982	13.9	22.2	19.6	14.85	48.49	31.63
50–54	407	913	1,320	25.4	26.7	26.3	27.82	61.57	44.78
55–59	418	730	1,148	26.1	21.3	22.9	33.59	58.82	41.19
60–64	318	394	712	19.9	11.5	14.2	31.01	38.30	34.66
65–69	137	140	277	8.6	4.1	5.5	18.15	16.76	17.42
70–74	30	25	55	1.9	0.7	1.1	6.18	4.37	5.20
75 or over	4	5	9	0.3	0.1	0.2	0.84	0.77	0.80
Total	1,600	3,421	5,021	100.0	100.0	100.0	7.33	15.02	11.29

Rates of first admissions per 100,000 population were low before age 45. They increased to a maximum of 44.8 at ages 50 to 54, and decreased steadily thereafter. Among males, the rates rose to a maximum of 33.6 at ages 55 to 59. Among females, the maximum rate, 61.6, was reached at ages 50 to 54. Except for some minor variations at advanced ages, the rates for females exceeded those for males at all corresponding ages.

Among males there was no significant trend between 1920 and 1930. (See Table 21.) It is possible that this resulted from a different classification of depressions, as a result of some changes in nomenclature. Between 1930 and 1940, however, the average annual rates increased throughout in significant degrees. There were similar increases between 1940 and 1950, beginning with age 45. The trends for females were quite similar. There were reductions between 1920 and 1930, but increases between 1930 and 1940, and between 1940 and 1950. The rates for 1950 were greatly in excess over those for 1920 among both males and females, the relative increases being greater for the males.

Manic-Depressive Psychoses.—There were 2,465 first admissions with manic-depressive psychoses during the three years ended March 31, 1951. (See Table 22.) Of this total, 830, or 33.7 per cent, were males, and 1,635, or 66.3 per cent, were

TABLE 21. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH INVOLUTIONAL PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 POPULATION, 1919–1921, 1929–1931, 1939–1941, 1949–1951

Males

Age (Years)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	b/a	c/b	d/c	d/a
30–34	....	....	....	....	....	....	....	....
35–39	0.08	0.06	0.30	0.30	0.75	5.00	1.00	3.75
40–44	0.65	1.53	5.03	3.50	2.35	3.29	0.70	5.38
45–49	6.14	5.73	10.64	14.85	0.93	1.86	1.40	2.42
50–54	7.52	8.21	20.83	27.82	1.09	2.54	1.34	3.70
55–59	11.59	12.99	20.93	33.59	1.12	1.61	1.60	2.90
60–64	11.30	9.07	11.50	31.01	0.80	1.27	2.70	2.74
65–69	6.88	4.96	9.23	18.15	0.72	1.86	1.97	2.64
70 or over	0.26	0.49	1.41	3.53	1.88	2.88	2.50	1.36

Females

Age (Years)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	b/a	c/b	d/c	d/a
30–34	....	0.06	0.11	0.59	....	1.83	5.36	....
35–39	1.07	1.08	2.08	3.41	1.01	1.93	1.64	3.19
40–44	7.77	7.25	18.96	21.84	0.93	2.62	1.15	2.81
45–49	21.88	13.19	41.32	48.49	0.60	4.13	1.17	2.22
50–54	26.88	19.27	48.84	61.57	0.72	2.54	1.26	2.29
55–59	25.94	17.13	37.07	58.82	0.66	2.16	1.59	2.27
60–64	17.77	9.53	18.42	38.30	0.54	1.93	2.08	2.16
65–69	10.88	5.95	8.20	16.76	0.54	1.38	2.04	1.54
70 or over	4.48	0.66	1.61	2.46	0.14	2.44	1.53	0.54

females. Males were admitted at a higher average age than females, the average ages being 44.3 and 40.8 years, respectively. The average for all first admissions with manic-depressive psychoses was 42.0 years. Half of the male first admissions were included in the range from 35 to 54 years. The corresponding range for the females was approximately 30 to 49.

The average annual rate of first admissions increased from minima at the younger ages to a maximum of 10.8 per 100,000 population at ages 40 to 44, and declined steadily thereafter. The trends were similar for the two sexes, but the rates for females were well in excess of those for males. The maximum rate for females was reached at ages 35 to 39. The maximum for males occurred at ages 40 to 44.

The average annual rates of first admissions with manic-

TABLE 22. FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1949–1951, AND AVERAGE ANNUAL RATE PER 100,000 POPULATION, CLASSIFIED ACCORDING TO AGE

Age (Years)	Number			Per Cent			Average Annual Rate per 100,000 Population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10.....	....	....	....	....	....	....	....	....	....
10–14	2	2	4	0.2	0.1	0.2	0.15	0.15	0.15
15–19	23	29	52	2.8	1.8	2.1	1.73	3.10	1.92
20–24	52	144	196	6.3	8.8	8.0	3.39	8.37	6.02
25–29	51	201	252	6.1	12.3	10.2	2.95	10.59	6.96
30–34	86	214	300	10.4	13.1	12.2	5.16	11.55	8.52
35–39	97	262	359	11.7	16.0	14.6	5.73	13.95	10.06
40–44	124	242	366	14.9	14.8	14.8	7.49	13.91	10.78
45–49	107	153	260	12.9	9.4	10.5	6.96	9.78	8.38
50–54	112	121	233	13.5	7.4	9.5	7.66	8.16	7.91
55–59	65	108	173	7.8	6.6	7.0	5.22	8.70	6.96
60–64	55	86	141	6.6	5.2	5.7	5.36	8.36	6.86
65–69	28	47	75	3.4	2.9	3.0	3.71	5.63	4.71
70–74	22	20	42	2.7	1.2	1.7	4.53	3.50	3.97
75 or over....	6	6	12	0.7	0.4	0.4	1.25	0.92	1.06
Total	830	1,635	2,465	100.0	100.0	100.0	3.82	7.18	5.54

depressive psychoses have been decreasing since 1920. (See Table 23.) Each decade showed lower rates than the preceding decade. A comparison between 1920 and 1950 shows that the rates were lower at every age in 1950.

Dementia Praecox.—There were 16,817 first admissions with dementia praecox between October 1, 1948 and September 30, 1951, of whom 8,300, or 49.4 per cent, were males, and 8,517, or 50.7 per cent, were females. Prior to 1940, males always exceeded females among first admissions with dementia praecox. A change became apparent in 1941, and the excess of females continued for almost a decade. It was felt that the reduction in the ratio of male first admissions may have been related to the war, since those who entered the armed services were in the age range applicable to dementia praecox. Furthermore, the sex ratio of the general population was altered during the war as a result of migration out of New York State. It is probable that these were important factors, since the proportion of males in this group of mental disorders has been rising in recent years. Nevertheless, females are still in relative excess, and this requires us to reconsider former

TABLE 23. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 POPULATION, 1919–1921, 1929–1931, 1939–1941, 1949–1951

Males

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
15–19	8.42	9.02	2.91	1.73	1.07	0.37	0.59	0.21
20–24	13.96	16.31	6.95	3.39	1.17	0.43	0.49	0.24
25–29	15.15	11.66	7.14	2.95	0.77	0.61	0.41	0.19
30–34	15.14	11.72	7.27	5.16	0.77	0.62	0.71	0.34
35–39	13.04	16.42	7.66	5.73	1.26	0.47	0.74	0.44
40–44	12.80	17.13	9.49	7.49	1.34	0.55	0.79	0.59
45–49	10.80	16.19	11.12	6.96	1.50	0.69	0.63	0.64
50–54	10.34	19.72	9.81	7.66	1.91	0.50	0.78	0.74
55–59	14.81	14.44	7.71	5.22	0.98	0.53	0.68	0.35
60–64	9.79	10.75	6.59	5.36	1.10	0.61	0.81	0.54
65–69	11.48	6.61	2.66	3.71	0.58	0.40	1.39	0.32
70–74	6.18	9.00	1.62	4.53	1.46	0.18	2.80	0.73
75 or over	3.16	2.14	0.88	1.25	0.68	0.41	1.42	0.40

Females

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
15–19	11.94	12.98	5.47	3.10	1.09	0.42	0.57	0.26
20–24	21.23	21.81	14.27	8.37	1.03	0.65	0.59	0.39
25–29	29.76	27.38	16.84	10.59	0.92	0.62	0.63	0.36
30–34	32.49	28.12	22.17	11.55	0.87	0.79	0.52	0.36
35–39	35.36	26.21	25.06	13.95	0.74	0.96	0.56	0.39
40–44	24.56	24.26	17.32	13.91	0.99	0.71	0.80	0.57
45–49	21.64	20.63	15.76	9.78	0.95	0.76	0.62	0.45
50–54	17.77	21.36	13.91	8.16	1.20	0.65	0.59	0.46
55–59	16.94	17.00	10.65	8.70	1.00	0.63	0.82	0.51
60–64	16.49	11.47	9.21	8.36	0.70	0.80	0.91	0.51
65–69	12.11	7.27	7.08	5.63	0.60	0.97	0.80	0.46
70–74	8.98	5.86	4.66	3.50	0.65	0.80	0.75	0.39
75 or over	3.65	1.00	0.46	0.92	0.27	0.46	2.00	0.25

impressions to the effect that dementia praecox is more prevalent among males than among females.

The average age of the 16,817 first admissions with dementia praecox was 32.6 years. (See Table 24.) Females were older, their average age being 33.9 years, compared with 31.3 for males.

The average annual rate of first admissions rose very rapidly among males to a maximum of 115.0 per 100,000 popu-

TABLE 24. FIRST ADMISSIONS WITH DEMENTIA PRAECOX, TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1949–1951, AND AVERAGE ANNUAL RATE PER 100,000 POPULATION, CLASSIFIED ACCORDING TO AGE

Age (Years)	*Number*			*Per Cent*			*Average Annual Rate per 100,000 Population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10	150	10	60	0.6	0.1	0.4	1.33	0.28	0.81
10–14	133	143	276	1.6	1.7	1.6	9.73	10.92	10.31
15–19	805	682	1,487	9.7	8.0	8.8	60.57	49.31	54.83
20–24	1,764	1,180	2,944	21.3	13.9	17.5	115.00	68.58	90.46
25–29	1,700	1,527	3,227	20.4	17.9	19.2	98.73	80.42	89.12
30–34	1,179	1,428	2,607	14.2	16.8	15.5	70.74	77.06	74.07
35–39	967	1,303	2,270	11.7	15.3	13.5	57.14	69.40	63.59
40–44	719	866	1,585	8.7	10.2	9.4	43.41	49.78	46.67
45–49	429	583	1,012	5.2	6.8	6.0	27.92	37.24	32.63
50–54	268	356	624	3.2	4.2	3.7	18.32	24.01	21.18
55–59	164	232	396	2.0	2.7	2.4	13.18	18.70	15.93
60–64	78	117	195	0.9	1.4	1.2	7.61	11.37	9.49
65–69	27	56	83	0.3	0.7	0.5	3.58	6.70	5.22
70–74	7	15	22	0.1	0.2	0.1	1.44	2.62	2.08
75 or over....	5	12	17	0.1	0.1	0.1	1.04	1.84	1.51
Unascertained	5	7	12	0.1	0.1	0.1	....	....	....
Total	8,300	8,517	16,817	100.0	100.0	100.0	38.21	37.40	37.80

lation at ages 20 to 24 years, and then declined steadily with advancing age. Females showed a similar trend, but the maximum rate (80.4) occurred later at ages 25–29. The male rates were well in excess of those for females through the interval 25 to 29 years. After age 30, the rates for females were in excess. The evidence is insufficient at present to determine whether the rates of first admission are higher among females in the older groups because of a later efflorescence of the disease, or because of social factors which delay their admission to mental hospitals.

The rates of first admissions with dementia praecox increased slightly among males between 1920 and 1930 at ages 15 to 19, but decreased between ages 20 and 34 years. (See Table 25.) Beginning with age 35, the rates increased substantially. With a few exceptions, the rates increased significantly between 1930 and 1940. The rates of increase were even greater between 1940 and 1950. Over the entire period between 1920 and 1930 the rates increased by from 30 to 150 per cent.

In the case of the females, there was no general trend

TABLE 25. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH DEMENTIA PRAECOX TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 POPULATION, 1919–1921, 1929–1931, 1939–1941, 1949–1951

Males

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
15–19	28.50	29.47	35.34	60.57	1.03	1.20	1.71	2.13
20–24	68.87	59.55	67.78	115.00	0.86	1.14	1.70	1.67
25–29	75.05	60.65	65.33	98.73	0.81	1.08	1.51	1.32
30–34	53.94	51.31	54.82	70.74	0.95	1.07	1.29	1.31
35–39	37.44	47.69	43.93	57.14	1.27	0.92	1.30	1.53
40–44	22.98	26.35	31.71	43.41	1.14	1.20	1.37	1.89
45–49	13.71	19.17	22.77	27.92	1.40	1.19	1.23	2.04
50–54	9.36	15.72	14.60	18.33	1.68	0.93	1.25	1.96
55–59	5.28	7.95	10.61	13.18	1.51	1.33	1.24	2.50
60–64	5.32	5.21	4.13	7.61	0.98	0.79	1.84	1.43
65–69	0.65	3.31	2.48	3.58	5.09	0.74	1.44	5.51
70–74	0.51	0.36	0.54	1.44	0.71	1.50	2.67	2.82
75 or over....	....	1.71	0.59	1.04	....	0.34	1.76	....

Females

Age (*Years*)	1919–1921 (a)	1929–1931 (b)	1939–1941 (c)	1949–1951 (d)	$\frac{b}{a}$	$\frac{c}{b}$	$\frac{d}{c}$	$\frac{d}{a}$
15–19	11.70	13.72	29.33	49.31	1.17	2.14	1.68	4.21
20–24	26.65	27.90	46.80	68.58	1.04	1.68	1.47	2.57
25–29	38.11	35.08	54.94	80.42	0.92	1.57	1.46	2.11
30–34	37.27	38.18	50.93	77.06	1.02	1.33	1.51	2.07
35–39	38.72	39.60	51.90	69.40	1.02	1.31	1.34	1.79
40–44	36.12	36.65	35.27	49.78	1.01	0.96	1.41	1.38
45–49	29.38	28.78	28.99	37.24	0.98	1.01	1.28	1.27
50–54	26.85	26.15	18.90	24.01	0.97	0.72	1.27	0.89
55–59	18.66	17.40	15.45	18.70	0.93	0.89	1.21	1.00
60–64	8.24	8.89	7.70	11.37	1.08	0.87	1.48	1.38
65–69	5.59	5.73	4.66	6.70	1.03	0.81	1.44	1.20
70–74	1.80	3.58	2.10	2.62	1.99	0.59	1.24	1.46
75 or over....	1.44	1.67	1.82	1.84	1.16	1.09	1.01	1.28

between 1920 and 1930, and between 1930 and 1940. The rates increased at the younger ages, which include the majority of first admissions with dementia praecox, but decreased at older ages. Between 1940 and 1950, however, all age groups showed increased rates, the increase varying from 20 to 60 per cent. Over the entire period from 1920 to 1950, all age groups, except those from 50 to 54, showed substantial increases in rates of first admissions.

SUMMARY

1. In general, the rate of first admissions to hospitals for mental disease in New York State is higher for males than for females.

2. However, there are some important variations in this respect. The senile psychoses, involutional psychoses and manic-depressive psychoses are more prevalent among females, whereas general paresis, alcoholic psychoses and psychoses with cerebral arteriosclerosis are more prevalent among males.

3. The average age of first admissions has increased by 7.7 years since 1920. All of the major groups of mental disorders showed an increase in the average age at first admission since 1920, with the exception of dementia praecox. The latter showed an average decline of almost a year.

4. There has been a continued increase in the number of first admissions of advanced age (*i.e.*, over 60), which has resulted in a continued increase in rates of first admission at such ages.

5. In general, rates of first admissions have increased since 1920. General paresis and the manic-depressive psychoses furnish exceptions to this trend, both having decreased significantly.

6. During the past decade there was a great increase in first admissions characterized as behavior disorders, most of them falling in the age group under 15 years. Dementia praecox was the predominant group in early maturity. The involutional psychoses and the alcoholic psychoses occurred most frequently in the forties and fifties. After age 55, the arteriosclerotic and senile mental disorders appeared in frequencies that increased rapidly with age.

7. In general, rates of first admissions increase with age, and are higher for males than for females at corresponding ages. An exception occurred between ages 25 to 39, where the rates for males declined and were exceeded by those for females.

8. Several groups of mental disorders have characteristic trends of their own with respect to rates of first admission. Thus first admissions with general paresis rose to a maximum rate among males at ages 55 to 59. Females reached their

TABLE 26. AVERAGE AGE OF FIRST ADMISSIONS TO HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1919–1921, CLASSIFIED ACCORDING TO MENTAL DISORDERS

Mental Disorders	*Average Age (Years)*			*Standard Deviation (Years)*		
	Males	Females	Total	Males	Females	Total
General paresis	43.89±0.13	40.77±0.30	43.35±0.12	9.42±0.09	9.96±0.21	9.59±0.09
Alcoholic	44.39±0.31	45.05±0.56	44.53±0.27	10.83±0.22	10.37±0.39	10.74±0.19
With cerebral arteriosclerosis	65.25±0.20	64.14±0.26	64.79±0.16	8.83±0.14	9.57±0.18	9.15±0.11
Senile	73.90±0.18	73.40±0.16	73.60±0.12	7.86±0.13	8.59±0.11	8.31±0.08
Involutional	55.54±0.27	53.23±0.18	53.81±0.15	6.66±0.19	7.46±0.13	7.33±0.11
Manic-depressive	37.17±0.25	36.39±0.16	36.66±0.14	13.82±0.18	12.46±0.12	12.96±0.10
Dementia praecox	30.14±0.09	35.72±0.14	33.55±0.08	8.83±0.07	11.14±0.10	10.27±0.05
All first admissions	41.56±0.10	43.94±0.11	42.69±0.07	16.73±0.07	17.31±0.08	17.04±0.05

TABLE 27. AVERAGE AGE OF FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1929–1931, CLASSIFIED ACCORDING TO MENTAL DISORDERS

Mental Disorders	*Average Age (Years)*			*Standard Deviation (Years)*		
	Males	Females	Total	Males	Females	Total
General paresis	44.57±0.14	43.06±0.31	44.28±0.13	10.27±0.10	11.18±0.22	10.46±0.09
Alcoholic	45.29±0.18	44.03±0.38	45.10±0.16	11.02±0.13	9.85±0.27	10.86±0.12
With cerebral arteriosclerosis	66.70±0.13	65.68±0.16	66.26±0.10	9.43±0.09	10.14±0.11	9.74±0.07
Senile	74.42±0.09	74.40±0.14	74.41±0.10	7.50±0.06	8.44±0.10	8.06±0.07
Involutional	54.86±0.24	52.11±0.19	53.06±0.15	6.76±0.17	7.17±0.13	7.15±0.11
Manic-depressive	38.51±0.21	36.17±0.15	37.12±0.13	13.66±0.14	12.45±0.11	12.99±0.09
Dementia praecox	31.65±0.10	35.94±0.12	33.48±0.08	9.99±0.07	11.48±0.09	10.87±0.06
All first admissions	44.36±0.09	45.61±0.10	44.91±0.07	17.41±0.06	18.13±0.07	17.74±0.05

TABLE 28. AVERAGE AGE OF FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1939–1941, CLASSIFIED ACCORDING TO MENTAL DISORDERS

Mental Disorders	*Average Age (Years)*			*Standard Deviation (Years)*		
	Males	Females	Total	Males	Females	Total
General paresis	46.91±0.16	44.30±0.32	46.28±0.75	11.12±0.11	12.69±0.23	11.58±0.10
Alcoholic	46.23±0.15	44.92±0.34	46.00±0.13	10.75±0.10	11.78±0.24	10.95±0.09
With cerebral arteriosclerosis	67.67±0.09	67.81±0.10	67.74±0.07	9.04±0.06	9.22±0.07	9.12±0.04
Senile	77.00±0.11	76.87±0.10	76.92±0.08	7.43±0.08	7.95±0.07	7.74±0.05
Involutional	53.92±0.16	51.41±0.10	52.16±0.08	6.89±0.11	6.64±0.07	6.81±0.06
Manic-depressive	40.50±0.26	38.06±0.17	38.84±0.14	12.92±0.19	12.34±0.12	12.51±0.10
Dementia praecox	33.27±0.09	31.30±0.10	32.29±0.07	10.48±0.07	11.17±0.07	10.86±0.05
All first admissions	47.94±0.08	49.06±0.09	48.47±0.06	18.73±0.06	19.32±0.06	19.02±0.04

TABLE 29. AVERAGE AGE OF FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, DURING 3 YEARS ENDED SEPTEMBER 30, 1951

Mental Disorders	*Average Age (Years)*			*Standard Deviation (Years)*		
	Males	Females	Total	Males	Females	Total
General paresis	51.46±0.28	47.41±0.50	50.27±0.24	11.95±0.20	13.97±0.35	12.47±0.17
Alcoholic	48.61±0.16	45.49±0.27	47.86±0.13	11.85±0.11	11.14±0.19	11.30±0.09
With cerebral arteriosclerosis	71.00±0.08	71.48±0.08	71.23±0.06	8.75±0.06	8.92±0.06	8.83±0.04
Senile	78.44±0.09	78.82±0.07	78.68±0.06	7.39±0.06	7.47±0.05	7.44±0.04
Involutional	56.41±0.11	52.98±0.08	54.06±0.07	6.77±0.08	7.21±0.06	7.26±0.05
Manic-depressive	44.33±0.32	40.78±0.22	41.97±0.18	13.53±0.23	13.00±0.16	13.28±0.13
Dementia praecox	31.25±0.08	33.88±0.08	32.58±0.06	10.99±0.06	11.44±0.06	11.30±0.04
All first admissions	49.28±0.08	51.36±0.08	50.34±0.06	20.71±0.06	20.83±0.06	20.79±0.04

maximum rate at an age about 5 years younger. Rates of first admission with alcoholic psychoses rose to a maximum among males at ages 45 to 49, and reached a maximum among females at ages 40 to 44. In the involutional psychoses, males reached their maximum rate at ages 55 to 59, females at ages 50 to 54. In the manic-depressive psychoses, females reached their maximum rates between 35 and 44, whereas the male rates remained relatively high until ages 50 to 54. Males reached their maximum rates of first admission with dementia praecox at ages 20 to 24. Females reached their maximum at ages 25 to 30.

STRUCTURE AND FUNCTIONS OF THE MENTAL HEALTH SOCIETY*

E. E. KRAPF, M.D.

Buenos Aires

STRICTLY speaking, it is not correct to refer to *the* mental health society, for there are at least two types of mental health societies with different structures and functions. I propose to call them the technical and the inspirational mental health societies. In introducing this terminology, I purposely avoid the usual names of professional and lay societies. There is, of course, no doubt that technical societies are usually organized along professional lines and that in inspirational societies the lay element often predominates. It must, however, be said—and saying it is not quite as redundant as might appear at first sight—that not only do inspirational societies need professional coöperation, but also the technical ones a certain amount of inspirational impetus. In other words: neither the technical nor the inspirational approach is sufficient in itself, and as, for obvious reasons, technical societies tend towards a certain onesidedness in their way of looking at things, it is perhaps justified calling the general mental health society with its blending of technical and inspirational interest *a fortiori the* mental health society.

There is a notion, current in many parts of the world, according to which the so-called general mental health society should not be general at all. It should be an association of well-meaning lay people characterized by a desire to fill their brains with much-needed information and to empty their purses in the interest of better mental health for everybody. Far be it from me to want to minimize the importance of this filling and emptying process. There is certainly no doubt that it is a good thing if people are properly informed, and an even better thing if they are warned against the current fads of popular psychology and medical practice. There is even less doubt that it is desirable for people to spend the

* Presented at the Fifth International Congress on Mental Health, Toronto, Canada, August 17, 1954.

money they have for humanitarian purposes, on something which, as mental health does, is likely to improve life on a large scale instead of benefiting only the victims of one very pitiable, but sometimes fairly infrequent, disease or infirmity. All this requires, of course, the imparting of proper information by the professionals and technicians. If, however, as a result of all this, the structure of the mental health society becomes that of a classroom where an omniscient teacher tells the children what they have to know, believe and do, the practical gain is right from the start severely limited. To begin with, it is not good for the mental health of the "children" to be treated this way, and they consequently very often react by closing their brains and their purses. But it is possibly even worse for the mental health of the "teachers," whose tendency towards narcissistic omnipotence is, I am afraid, all too easily enhanced.

It is, in fact, my conviction that the professionals need just as much guidance from the lay people as the latter from the technicians, and that, quite apart from what importance this consideration may have for the life of the mental health society itself, there is no technician whose activities cannot be very much improved if he has the opportunity of seeing what he does and does not do against the background of a free and easy exchange of opinions with people who are possibly in some respects less blind because it is not their job to stare constantly into the light of specialized knowledge.

In speaking of lay people, I mean in this context not only what one might call the absolute layman: the banker, the housewife, the carpenter, and the art student. The mental health field—such as we look at it nowadays as comprising not only the prevention of overt mental disorder, but also that of the so-called normal tensions in human relations—this field is so enormously wide that no technician can hope not to be a layman in some of its areas. One can hardly expect anybody to be at the same time a specialist in psychiatry, psychology, sociology, moral theology, criminology, public health, pedagogics, nursing, labor problems and so on. On the other hand, it is an exceedingly healthy experience for any technician—and particularly for the psychiatrist who, for obvious reasons, usually plays an outstanding rôle in mental health societies—to realize just how much he does not

know and how necessary it is for really good mental health work to take into account everything that is known about human relations and human tensions. We all remember that the creation of the World Federation for Mental Health was preceded by the get-together of 26 technicians in an International Preparatory Commission, whose task it was to prepare a statement on mental health for the London Congress. In the course of this meeting each member was asked to write a statement on what he thought mental health was. The participants had, of course, a certain common background, but even so there was a wide divergence in their ways of approaching this basic concept. Is mental health intellectual health, or emotional health, or instinctual health, or moral health, or individual health, or social health? In all likelihood it is all these, but if we all get stuck in our different routines, we have a good chance of becoming like that association of the blind which wanted to make a study of the elephant, but could never arrive at anything practical because there were too many schools of thought—the most irreconcilable being the trunk school and the tail school.

Structurally speaking, it would not be a bad thing if every mental health society made an analytical study of its membership every one or two years. In other words: there should be an effort to find out about the proportions of the different elements associated. Are there too many technicians or too many laymen? Too many old people or too many youngsters? Too many men or too many women? Too many employers or too many employees? Too many civil servants? Too many ministers of religion? Too many doctors? Too many psychiatrists? I am quite certain that it would contribute to the vitality of any mental health society if they not only desired to increase the membership as such, but also to balance it by trying to rope in the lawyers, trade union officials, and rabbis who are possibly missing.

Another structural aspect is to be derived from what I have just said. If all the benefits of multiprofessionality (or better, generality) are to be reaped, it is necessary to bring the membership into real and intimate contact. A mental health society can to a certain extent comply with this need by facilitating joint meetings of technicians, but undoubtedly it will do an even better job if it sets up mixed working

groups within its own framework. Whoever has worked in and with a discussion group knows to what extent the current prejudices against psychiatrists, civil servants, judges, and the clergy dissipate as soon as they are experienced in the free-and-easy give and take of a group discussion. I know of one mental health society where every member is assigned to a committee, and I have seen people smile at this apparent symptom of over-organization. I am certain, however, that this type of universal grouping is a very sound move because, quite apart from its objective benefits, it surely helps members to realize that mental health is not something which is handed down to others, but something which has to be worked out in a participating experience by every one of us for himself.

As could be expected, I could not speak about the structure of the mental health society without, at the same time, touching on its functions. Unwittingly, however, I did even more. The structure of the mental health society to which reference was made in the beginning is only meaningful if, as I believe it to be, the main function of the general mental health society is educational.

There are always people who distrust the power of the educational word which is for them only so much hot air and who therefore want to "do something." As they are often particularly energetic and powerful people, they succeed quite easily in convincing the rest of the correctness of their view. The result usually is that the mental health society is saddled with a special school, a child guidance clinic or a home for alcoholics; in other words: with enterprises which are bound to lead to far too strong a drainage of the society's resources, both of finances and personnel, and which in any case, not only ought to be managed by the community as a whole, but which, in all likelihood, would be better managed by a more or less official body.

This should not be interpreted in the sense of my being opposed to mental health societies "doing something" beyond education, in certain special circumstances. I believe, for instance, that it is not only legitimate for a mental health society, but, in a way, even its duty to organize the more experimental type of enterprise, if the community as a whole is not prepared to pay for such a pilot run and if the mental

health society is financially in a position to make the necessary outlay without curtailing its normal educational program. Even so, the society should, I think, envisage right from the start the convenience of handing over the new well-baby clinic or the new reintegration center for older people to the community as a whole as soon as their necessity is proven and the community is ripe to take over.

I need hardly point out that this sort of "doing something" is still educational in purpose. It may, in fact, turn out to be particularly effective education for the community as a whole, more effective, anyway, than the distribution of leaflets and the coverage of walls with posters, and sometimes even more than public addresses or theoretical lecture courses. When Sigmund Freud was asked what could be done in order to overcome the prejudices against psychoanalysis, he advised his pupils to go on working and producing increasingly satisfactory results. I have no doubt that this can be applied to the whole of the mental health field. In the long run, the only propaganda which convinces is the adequate presentation of facts.

Incidentally, there is at this point the possibility of another avenue towards doing things and spending money. All education is based on the proposition of ideals to be attained, or, to put it otherwise, of ideal needs to be created. Everybody knows these days that many psychiatric hospitals could be better equipped and better run, that there should be psychiatric wards in general hospitals, that the treatment of prisoners could be improved by the introduction of psychotherapeutic principles, that child guidance clinics and parent education centers are necessary, that the idea of mental health should pervade the education in schools, that public administration—medical and otherwise—would be eminently more successful if they had more knowledge about matters psychological, that the relationship between management and labor could be much improved if it were to be looked upon as a problem of human relations as well as a problem of finances. But this is theoretical knowledge as long as no effort is made to find out on the local level just how far-distant reality is from the ideal. It is therefore one of the legitimate tasks of a mental health society to help in the process of fact-finding which is so necessary in order to plan any improvement. In

other words: the mental health society has an important function in the stimulation and facilitation of mental health research, and there is no need to stress to what extent this common task of laymen and technicians will strengthen their collaboration within the society.

Of course, needs should not only be seen, but also voiced. It will not do any harm to be in close contact with the press and the body politic in order to push the community as a whole in the right direction. On the other hand, a good mental health society will know enough about mental health to realize that nobody wants to be pushed, and that everybody prefers to discover the truth as if he were the first to discover it. The principle stated above, that fact-finding has a priority over talking and exhorting, belongs in the sphere of what one might call the sound strategy of human relations. It should never happen (or at least only in extreme cases) that a community leader at the sight of a mental health delegation sighs: "There are those terrible people again." It should always be tried to bring him to a point where in certain situations he would say to himself: "Well, I'd better ask those mental health chaps about this."

Generally speaking, it would seem that the structural analysis of the mental health society which I suggested a short while ago could be complemented quite profitably by a functional analysis on the lines of a periodic self-examination as to what new facts have been discovered and how many new friends have been made.

I should not like to end my remarks without saying a few words about the world-wide implications of local mental health work. I realize, of course, that I expose myself to the interpretation that I am speaking *pro domo*. But I am not afraid of this, because I am not ashamed of speaking *pro domo*. It is obvious that any mental health society has its main obligations at home. On the other hand, it cannot be doubted by anybody that we are all increasingly living in "one world," and that we are not only morally responsible for our neighbors' well-being, but also forced by necessity to care for it. It is not mere chance that the World Federation for Mental Health was founded in the aftermath of the most destructive war mankind has ever fought. It is not chance either that the main subject of the London Congress was "Mental Health

and World Citizenship." It belongs to the functions of even the smallest mental health society of the smallest community in the smallest country to help in the finding of facts and in the setting of ideals for the whole world. The World Federation for Mental Health is more than just a roof organization which the mental health movement could at a pinch do without. It is the most necessary organ for dealing with the international problem of mental health—or, maybe, even with the problem of international mental ill-health—through which the local mental health society can carry out its duty to function also beyond its own limited frontiers.

SUMMARY

First of all I distinguish between technical and inspirational mental health societies, and point out that not only do inspirational societies need professional coöperation, but also the technical ones inspirational impetus. The professional person is far from being omniscient, he needs guidance from lay people, not only from the "absolute" laymen, but also from other professionals who are lay people from the point of view of his own specialty. A periodic analysis of the membership is recommended, with a view to obtaining and maintaining adequate proportional representation of different groups. There should be as much group work as possible, as the main function of the general mental health society is educational, the tendency to "do something" outside the province of education should be curbed. Experimental enterprises are educational in nature and, as such, may well be undertaken. But the most legitimate task of the general mental health society is to help in the process of fact-finding which is so necessary in order to plan any improvement. Needs should certainly be voiced, but this should be done tactfully. The structural analysis recommended should be paralleled by a functional analysis as to what new facts have been discovered and how many new friends have been made in the community. In conclusion, I point out that every local mental health society has an international responsibility and function.

THE RELATIONSHIP OF MENTAL HEALTH SOCIETIES TO GOVERNMENTS*

RUDOLPH G. NOVICK, M.D.

Medical Director, Illinois Society for Mental Health

THE relationships between agencies—voluntary and voluntary, governmental and governmental, and voluntary and governmental—are becoming increasingly complex. The emerging recognition of the inter-relatedness of such problems as social maladjustment, dependency, and ill-health—physical and psychological—and various social, cultural, political, economic, and psychological factors [1, 2] are literally forcing organizations to realize that various community organizations—health, welfare, education—can operate more effectively as inter-dependent agencies rather than as separate entities.

Mental health societies themselves are agents of synthesis. They bring together knowledge and methods of practice from, say, psychiatry, psychology, social work, and education, and convert them into mental health programs. Based upon their recognition of the fact that a mental health program is the summation of the kinds of services that are given by *all*

* Presented at the Fifth International Congress on Mental Health, Toronto, Canada, August, 1954.

[1] This recognition has been fostered by our maturing social consciousness, our increasing knowledge of the social sciences, and the slowly progressing synthesis of gains made through specialization developed in the last century and in the early part of this century.

[2] Among the factors contributing to a convergence of interests and activities are:

(a) The increasing knowledge of the dynamics of human behavior and the principles of community organization;

(b) The growing acceptance of psychologic determinism as a factor in all causation and as a major "cause" in some types of human behavior;

(c) The shifting emphasis from a repressive and palliative approach to a therapeutic and preventive approach; and

(d) The emerging concern with the setting in which the individual lives and the forces which bear upon human behavior, as well as a concern with the individual himself.

agencies—not only those rendered by "mental health" agencies—the societies have related themselves to a large number and variety of social agencies. They have attempted to operate within the mainstream of community life. By various means and with varying degrees of success, they have attempted to participate in, coöperate with, and coördinate and integrate the programs and activities of other organizations. In this capacity, the mental health societies have served not only as agents of synthesis, but also as catalysts—attempting to accelerate the awareness of other agencies to the mental health implications in their programs and activities and in their methods of operation and procedure.

Efforts to achieve better coördination of programs and services have been characterized by fluctuations between progress and retrogression. There are many barriers to steady, forward progress. Divergent forces [1] co-existing with convergent forces have created a situation wherein the relationship between agencies can best be described as that of "antagonistic coöperation." Much remains to be done to achieve better integration. The mental health societies must bear their share of responsibility for this task.

An historical perspective is basic to any understanding of the relationship between mental health societies and governmental agencies. In the early colonial days, our treatment of the mentally ill reflected that of England. Following the principles set forth in the Elizabethan Poor Laws, the local colonial authorities were responsible for poor relief, including help to the "insane." If the family was poor, the local colonial authorities grudgingly provided "out-door relief" (a financial stipend to the family of the mentally-ill individual); later, when the facilities became available, the authorities placed some mental cases in jails and almshouses. With the establishment in 1773 of a state hospital at Williamsburg, Virginia set an example of state responsibility. This example

[1] Some of these forces have been identified and analyzed; others have been identified, but await a more complete analysis; still others remain to be identified. Illustrative of such barriers are: inertia, indifference, and apathy; fears regarding sovereignty and proprietary rights; the need of agencies to maintain their identities; inequality of intellectual understanding and emotional acceptance of factors which make coördination and integration desirable and imperative; and gaps in specific knowledge of human behavior, interpersonal relations, and of institutional settings which influence human behavior.

of state support was not immediately followed, however, and "out-door relief," jails, and almshouses continued to be utilized by local authorities.

The years from 1800 to 1825 are regarded as the pioneer period of private general hospitals, and "asylums" for the insane resulted from segregating the mental patients of these early private hospitals. Such was the origin of the New York Lunatic Asylum (1805) and of the McLean Asylum of Boston (1818). Asylums also arose through private philanthropies, two examples of which were the Friends' Asylum at Frankford (Philadelphia, 1817) and the Hartford Retreat (1824). These early philanthropic institutions undoubtedly served, as private institutions often have, to provide free experiment at a time when state establishments were either non-existent or too much regimented for this purpose.[1] The extent of the problem of mental illness and the limitations of private philanthropy made obvious the fact that systematic provisions for mental patients would have to come from governmental sources.

The 1830's ushered in the present era of state mental hospitals. From this beginning, governmental responsibility grew[2] and continues to grow.

Voluntary groups, after having pricked the public conscience and goaded it into accepting responsibility for the institutional care of the mentally ill, next concerned themselves with attempts at reform in the institutional programs. At first, organized leadership was provided by the Conference of Boards of Public Charities and Corrections (later known as the National Conference of Social Work) and the National Association for the Protection of the Insane and the Prevention of Insanity. Since 1908, the leadership has been provided by the organization now known as the National Association for Mental Health[3] and the state and local mental health societies.[4]

[1] See "The Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association" by Richard H. Shryock, *One Hundred Years of American Psychiatry*. New York: Columbia University Press, 1944. P. 17.

[2] In 1951, governmental facilities provided over 97 per cent (Federal 8.7 per cent; State 85.4 per cent; County, 3 per cent) of the total number of psychiatric beds in the United States.

[3] Then known as the National Committee for Mental Hygiene.

[4] There are today 29 state mental health societies affiliated with the National Association for Mental Health.

Their efforts, in the beginning, may be described as an "asylum reform movement." Their programs were couched in terms of asylum care. Their concern was the insane individual. Their zeal and enthusiasm were vented against cruelty, abuse, and neglect. Their primary concern was to humanize the care of the insane. Reform efforts, in keeping with present-day concepts of what constitute cruelty, abuse, and neglect continue. Illustrative of such efforts are the intensive legislative campaigns of the Michigan Society for Mental Health in behalf of a bond issue to plan, construct, and equip hospitals, and thus reduce over-crowding in state mental hospitals; and of the Illinois Society for Mental Health for a commitment law, aimed at minimizing the quasi-criminal procedures based on archaic concepts of insanity, and replacing it with a law which is therapeutically, rather than punitively, oriented.

Under the leadership of Dr. Thomas D. Salmon[1] in the first quarter of this century, the mental hygiene movement assumed a more positive and constructive approach. By means of surveys, demonstration projects, educational programs, and legislative campaigns, the mental hygiene societies launched a drive—still far from its goal—aimed at improving and expanding the program of institutional care and of developing extra-mural psychiatric services.

Improvement of the institutional programs has been achieved by means of surveys and studies, such as those conducted by Dr. Salmon[2] and Mr. Raymond Fuller[3] of the National Association for Mental Health; by Mr. Samuel Whitman of the Cleveland Mental Health Association;[4] and by the Hospital Inspection and Rating Service, sponsored and partially financed by the National Association for Mental

[1] Dr. Salmon first served as director of a series of mental hygiene studies (1912–15), and then (1915–21) as medical director of the National Committee for Mental Hygiene.

[2] See "The Mental Hygiene Movement," American Foundation for Mental Hygiene, Inc., 1938, p. 331.

[3] See "A Study of Administration of State Psychiatric Services" by Raymond G. Fuller, MENTAL HYGIENE, Vol. XXXVIII, No. 2, April, 1954.

[4] See *A Survey by the Cleveland Mental Health Association—To Provide Data About A: The Number of Cuyahoga County Residents Known to be Under Care of Medically Supervised Psychiatric Resources; and B: The Number of Cuyahoga County Residents Needing Treatment and Care for Mental Disorders*, by Samuel Whitman.

Health, and conducted by the Central Inspection Bureau of the American Psychiatric Association.[1] These and other surveys and studies have contributed immeasurably to raising mental hospital standards, improving institutional programs, modernizing laws affecting the mentally ill, and bettering the administrative structures of the official departments responsible for mental health programs.

To a considerable degree, improvement and expansion of the institutional programs conducted by governmentally operated agencies have been realized by means of demonstration projects sponsored, conducted, and financed by mental health societies. Because of their greater freedom from political control, their greater flexibility, and their more individualized approaches—as compared with governmental agencies—mental health societies have a unique opportunity to carry on demonstration projects and develop new fields of service, new techniques, and new methods, until such time as the value of these have been demonstrated and until the official agencies are prepared to assume responsibility for them. It was by such means that occupational therapy and social work, for example, were introduced into the Illinois state mental hospital system.

In 1915, the Illinois Society for Mental Hygiene opened the John B. Favill School of Occupations to test the value of occupational therapy as an adjunct in the treatment of the mentally ill and to train occupational therapists. Students of the school, during its five years of operation, contributed over 3,000 work days to the state mental hospitals. Its graduates served as construction aides during World War I, and also as occupational therapists in general and mental hospitals. The value of the project having been demonstrated by the Illinois Society, the State of Illinois then assumed responsibility. The Society's director was appointed director of occupational therapy for the state mental hospitals, and was charged with the responsibility of organizing an occupational-therapy program in each of the hospitals.

[1] The National Association for Mental Health co-sponsors and gives partial support to the Central Inspection Bureau of the American Psychiatric Association. The actual inspection and rating are conducted by the American Psychiatric Association. "The C.I.B. reports . . . serve as a springboard of activity by the state and local mental health associations toward improvement of hospital conditions." (*N.A.M.H. Annual Report, 1952–53.*)

The Society's demonstration project on the value of social work in pre-parole investigations and in after-care of patients discharged from state mental hospitals [1] resulted in the introduction and eventual incorporation of these services into the state mental hospital program. This project stimulated the interest of a county judge, who requested the Society to conduct a study to test the value of pre-commitment social work. After a four-year study, this work was taken over by the county. The director of the project and three assistants were retained by the county to function as the social service bureau of the Psychopathic Unit of the Cook County Hospital.

Mental health societies have played, and continue to play, a significant rôle in the next important development in programs for the care of the mentally ill—the establishment of mental hygiene and/or child guidance clinics. Projects, and the processes involved therein, which illustrate the relationship between mental health societies and governmental agencies are the mental hygiene clinic demonstration project—sponsored, financed, and partially staffed by the Illinois Society for Mental Hygiene, and the child guidance demonstration clinic project—financed and conducted by the National Committee for Mental Hygiene. In the former, the Society formulated plans for the clinic, supplied office space, and provided the services of a social worker, while the state hospital provided a psychiatrist. After the value of the clinic had been demonstrated, the State of Illinois assumed this responsibility. This marked the beginning of the state's mental hygiene clinic program. The child-guidance demonstration-clinic project contributed immensely toward furthering the concept of the team-approach and of the importance of extramural psychiatric services.

Another means effectively utilized by mental health societies to create new services or programs is to call attention to an existing need and to provide the leadership in united planning to meet that need. In 1944, for example, when there was great need for specialized services for veterans discharged

[1] The use of social workers for work with discharged patients was introduced in Germany in 1829 and in France in 1841. It was not until the beginning of the twentieth century that similar programs were initiated in the United States. It was a voluntary agency, the New York State Charities Aid Association, that experimented with and demonstrated the value of an after-care program which was then taken on as a state responsibility.

for neuropsychiatric reasons, the Illinois Society for Mental Hygiene, in order to stimulate intelligent interest, devoted its annual meeting to the theme of the psychiatrically-handicapped veteran. It then called:

> "... a conference of leaders of all interested representative groups and agencies—to pool information on present and proposed programs. The unmet needs were pointed up. A technical committee (appointed by the Society) drew up a proposal for a pilot service for the care of the ambulatory non-service-connected neuropsychiatric dischargee, who seemed to be the particular responsibility of the State. Auspices for the project were explored and finally the program was adopted *in toto* by the Illinois Department of Public Welfare as an extension of its extra-mural program."[1]

A similar procedure was followed by the Society in its planning for an in-patient facility for emotionally disturbed children. The Society provided the leadership, served as an integrator and catalyst, and, with the coöperation of official and unofficial agencies, realized a plan for the establishment of the William Healy Residential School[2] by the Illinois Department of Public Welfare.[3]

The convergence of social work and psychiatry and the development of clinics and their incorporation into the structure and function of the mental hospitals have helped to usher in and to foster a new, a broader, and a more challenging concept of psychiatry. By and large, however, psychiatry remained a cloistered procedure. It continued very largely to be patient-oriented, with its major concerns being mental illness and personality disorganization.

These developments, however, were prerequisites to further progress. They served to extend the horizons and to open up new vistas. The psychiatric insights gained by these means, and the promising results of these procedures encouraged and stimulated efforts aimed at (1) broad application of psychiatric understanding of human behavior to the problems of ordinary people, (2) modification of social institutions and stress situations which are detrimental to mental

[1] See "Professional Responsibility for Community Mental Health" by Iva Aukes and Rudolph G. Novick, M.D., MENTAL HYGIENE, Vol. XXXV, No. 3, July 1951.

[2] See "Planning for the Emotionally Disturbed Child," Illinois Society for Mental Health, Inc., March, 1949.

[3] See "New School Dedicated to Honor Dr. Healty," Illinois Department of Public Welfare, *The Welfare Bulletin*, XXXXIII, No. 6, November-December, 1952.

health, and (3) involvement not only of social workers and psychologists, but also of educators, clergymen, correctional authorities, nurses, and all others engaged in the individualized helping process.

In this favorable climate, mental hygiene societies and mental hospitals raised their sights, and began to experiment with ways and means of (1) preventing mental illness and promoting mental health, (2) involving more and more people in their work, and (3) developing new relationships—relationships not limited to the official mental health agencies, but extended to include such official agencies as those concerned with health, welfare, education, and others concerned with social adjustment. Voluntary and official agencies have joined forces to promote mental health education for, and wider participation on the part of, the general public,[1] selected segments (*e.g.*, parents and adolescents) within the general population,[2] and professional groups (*e.g.*, doctors, nurses, educators).[3, 4]

[1] Mental Health Week activities, sponsored jointly by voluntary mental health societies and official agencies, exemplify such joint effort toward educating the public in the basic facts about mental health and mental illness and provisions therefor.

[2] *Pierre the Pelican*—produced by the Louisiana Society for Mental Health and distributed, in many instances, by official agencies—health, mental health, and welfare—exemplifies a joint effort in the field of mental health education directed toward selected segments of the population. One series of pamphlets is designed for parents of first-born, and cover good principles of child-rearing beyond the area of physical care. Other pamphlets, for other groups, are available.

[3] The following reports illustrate the collaborative efforts of mental health organizations and educators to filter mental health principles and practices through the educational process to further individual development and to promote mental health:

(1) Mental Health Association of Delaware, "Promotion of Mental Health in the Primary and Secondary Schools: An Evaluation of Four Projects," Group for the Advancement of Psychiatry, *Report No. 18*, January, 1951.

(2) Massachusetts Association for Mental Health, "Some Applications of the Concepts of Group Interaction to the School Program," *Newsletter*, Mass. Association for Mental Health, December, 1953.

(3) National Association for Mental Health, "Mental Hygiene Project, Public School 33, New York City," *Annual Report, 1948–49*, p. 41.

Official educational agencies have coöperated at different levels in these and similar undertakings.

[4] Illustrative of joint efforts—planning, implementing, and financing—of mental health educational projects for professional groups are the Institute on Nursing Education ("Personality Development and its Implications for Nursing and Nursing Education," Illinois Department of Public Health, 1949), and the Mental Health Institute for Medical Health Officers. The State of Illinois depart-

The next, most recent, and most significant development in our approach to the problem of mental illness was the passage in 1946 of the National Mental Health Act. This Act created the National Institute of Mental Health; provided funds for research in mental health and mental illness, for training of psychiatric personnel, and for grants-in-aid to states for programs devised to prevent mental illness and promote mental health. The Act was the result, in large part, of the intensive campaign for increased federal support in the fight against mental illness, begun in 1942 by the National Committee for Mental Hygiene, under the capable leadership of its medical director, Dr. George S. Stevenson. Dr. Stevenson ". . . repeatedly emphasized the need for a bigger program than any that could be carried out by private initiative."[1] The National Committee discussed the whole matter with various members of Congress, consulted with representatives of the U. S. Public Health Service, prepared the draft of a bill which served as the basis for the National Mental Health Bill, and mobilized the support of state and local mental hygiene societies in behalf of the Bill. Since 1946, representatives of mental hygiene societies have appeared regularly before Congressional appropriations committees, and they have stressed the importance of adequate appropriations to implement the provisions of the Act. Mental health society representatives have held appointments on various advisory committees to the National Institute of Mental Health, which is responsible for the administration of the Act.

The significance of the Act and its tremendous potentialities for advancing psychiatric frontiers is inherent in its broad concept of mental illness and mental health; its emphasis on research, to learn the causes, methods of prevention, and treatment of mental disorders; and in its program for positive action to:

1. Promote mental health, by assisting people in the acquisition of knowledge, attitudes, and behavior that will foster, maintain, and improve their mental health.

---

ments of health, education, and welfare and the Illinois Society co-sponsored these projects, which were financed by funds made available to the state under the National Mental Health Act.

[1] See "Finding a Way in Mental Hygiene," National Committee for Mental Hygiene, Inc., *Annual Report*, 1945, p. 27.

2. Prevent mental disorders by control of biological, interpersonal, and social factors that jeopardize mental health.
3. Restore to health those persons with mental disorders, by providing treatment and rehabilitation services.[1]

Today, in the parallel yet converging interests and activities of voluntary and governmental agencies, we have a reflection of the growing acceptance of a concept of social justice which recognizes the right of an individual to share in the advantages which result from equality of opportunity, economic security, and good health. This concept of social justice contrasts with that of dispensing such rights on sufferance, an impersonal, condescending public charity, and/or as the expression of an emotional outlet for a too-personal "lady-bountiful" from such voluntary agency. Today, an ever-growing segment of the population regards mental illness as a medical problem, and a good beginning has been made in the process of synthesizing of mental health and public health. Today, we are witnessing marks of a growing awareness of the fact that mental illness is not only a medical problem, but that it is also an economic, social, and political problem.

The National Mental Health Act, itself a product of this climate and of the effective collaboration of voluntary and official agencies, has contributed significantly to the forward surge on this wide front and to closer contact between voluntary and governmental agencies. This has been achieved through leadership provided by the National Institute of Mental Health, and by means of technical advice and financial assistance to official and voluntary agencies.

However, the very act of rapprochement—desirable, essential, and significant as it is for further progress—has produced friction, tension, and, at times, even hostility between mental health societies and governmental agencies.[2] Agency administrators—public and private—have reacted in a variety of ways to the differences of opinion, the frictions, and the tensions which the sharing of the same fields of interest and activity, and the interdependence of one on another have produced. Some, in both groups, have failed to view these

[1] See "Program Development" in *Mental Health Program Guide*, Vol. 2, 1/15/54, II-1, U. S. Department of Health, Education and Welfare.

[2] Some of the dynamics of such tension are discussed by Dr. George S. Stevenson: "Dynamic Considerations in Community Functions," MENTAL HYGIENE, Vol. XXXIV, No. 4, October, 1950, pp. 531–546.

frictions, at least in part, as evidence that the two groups have drawn together closely enough so as to have conflicts. They interpret differences of opinion and approach as evidence of unjust criticism, unfair treatment, and political connivance on the part of one or the other—depending upon personal affiliation or alignment. They view each other with mistrust and misgiving. They wish to eliminate totally these conflicts at any cost. In their anxiety to accomplish this end, they fail to realize that the total elimination of friction is an undesirable and unrealistic objective, and that conflict—if it does not degenerate into warfare—can be healthful.

By recognizing the healthful or positive aspects of the situation, mental health societies and governmental agencies will be in a better position to study objectively and evaluate scientifically the various factors—psychological, political, economic—which contribute to misunderstanding, friction, and hostility. This increased understanding and scientific approach will enable them to devise ways and means of alleviating tensions and of re-channeling their energies into more constructive activities in keeping with their traditional functions.

Whereas, ". . . many voluntary health agencies are committed to a policy that looks to a complete absorption of their activities by official agencies or to the substantial solution of their major problems,[1] mental health societies are not so committed and cannot foresee the time when such a state of affairs might obtain. The responsibilities which are, or should be, carried by mental health societies are greater than ever. There are many unsolved and pressing problems related, in general, to economic, political, social, and technical changes, and more specifically—to the increasing responsibility and expanded programs which are being assumed by governmental agencies. In relation to the latter—the assumption of new responsibilities and expanded programs by governmental

[1] "The goal of the Planned Parenthood Federation, for example, would be largely attained if state and local departments of health would provide child-spacing clinics, as a number now do. The local chapters of the National Foundation for Infantile Paralysis could not long justify their existence or their present restricted programs if effective methods of prevention and cure of poliomyelitis were discovered or if the states established adequate facilities for treating all forms of crippling and for rehabilitating and training of all crippled persons." *Voluntary Health Agencies* by Selskar G. Gunn and Philip S. Platt. New York: The Ronald Press Company, 1945, p. 297.

agencies—the mental health societies not only must avoid obstructive tactics toward, but indeed must coöperate with, the official agencies. They must help these agencies, if such help becomes necessary, to defend themselves against criticism and attacks for having assumed the new responsibilities. They must support the efforts of governmental agencies to secure adequate funds to implement these new activities. They must help the public as well as the administrative and legislative branches of the government to understand the task of the mental health service—regardless of the particular agency (health, welfare, education) in which the service may be administratively lodged—and the objectives of the new service. Official agencies, on the other hand, must avoid an attitude of condescending superiority toward voluntary agencies. They must avoid the tendency to consider the relationship between the two in terms of hierarchic structure—of one as being over the other. The administrators of public agencies must recognize the historic rôle which mental health societies in the United States have played in improving mental health services—both as a stimulating factor and as a supplementary resource to official agencies. They must consider the relationship between themselves and the voluntary agencies as a partnership, with a division of labor.

The changes in social philosophy, the technical advances, and the political and economic changes have created many very real and difficult, but not insoluble, problems. They have brought to the fore some fundamental issues which public and voluntary agency administrators will have to face and jointly attempt to solve. There is urgent need for a critical and constructive review and re-evaluation of the concepts underlying our approach to the field of mental health and the problem of mental illness. The large and expanding rôle of government, for example, in the mental health field, raises many questions such as those related to the division of responsibility between the different levels of government—federal, state, and local—and the division of responsibility and labor between governmental and voluntary groups. The tendency to utilize ever-larger units of government [1] raises the question

[1] In early colonial days, local colonial authorities were responsible for poor relief, including help to the insane. The present era of state responsibility began in the 1830's. The federal government's activities in this field date back to the opening of St. Elizabeths Hospital in Washington, D. C., in 1855.

of the values gained and lost by such centralization. The high percentage of mentally ill hospitalized in governmental hospitals raises the question as to the advisability of, and the means for, developing alternatives to state hospitalization and the greater utilization of private resources.[1] The progress in psychiatric knowledge and the advance in psychiatric treatment, resulting in decreased periods of hospitalization and increased discharge rates, raise the question of the practicality of segregating the mentally ill in special (mental) hospitals. General hospitals, particularly private general hospitals, have evaded their duty for the care and treatment of the mentally ill requiring hospitalization. Only four per cent of the mentally ill are hospitalized in general hospitals.[2] In addition, the availability of public funds to mental health societies creates another problem and raises the question of the "contamination" of these agencies.[3]

[1] To the extent that the lack of adequate psychiatric facilities in private general hospitals is due to lack of funds, the inadequacy might, in part, be corrected by state subsidies to voluntary hospitals for construction and/or psychiatric services which would otherwise have to be undertaken or rendered by the state. Two states have such programs in operation: (1) New York is subsidizing two private general hospitals for in-patient and out-patient psychiatric services; (2) Vermont is reimbursing a private sanitarium for the care of psychiatric patients who would otherwise have to be committed to the state mental hospital.

[2] See "Present Status and Future Needs of Psychiatric Facilities in General Hospitals in the United States and Canada," by A. E. Bennett, *et al.*, *American Journal of Psychiatry*, Vol. 108, No. 5, November 1951. On page 321 appears the statement: "Of the 574,683 beds, the 4,761 United States general hospitals provide only 24,000 psychiatric beds; that is, only 4 per cent of all general hospital beds are psychiatric. These beds accommodate only 1 per cent of all mental patients."

Related to this issue, is the discrimination against the mentally ill by insurance companies and various pre-pay hospital plans which do not cover the mentally ill nor defray the cost of caring for the psychiatric patient to the same degree as for the physically ill patient.

[3] The general consensus of mental health societies on the use of public funds is well expressed by statements recently received from two state mental health organizations. One writes: "The practice (with respect to the use of public governmental funds) . . . discourages the use of public funds for operating expenses of the Society and its special projects. It is generally felt that funds contributed voluntarily by citizens can more effectively be used to support our activities, while at the same time allow the state Society to serve in its capacity as a 'benevolent watch-dog' over those public or government operations in the mental hygiene fields. This is an added protection for our position as a constructive critic." The other: "State, federal and other public funds are used by the Association for special projects. . . . It is our . . . policy that no state or federal funds will be used for general operating expenses."

In conclusion, I should like to state that there still are, and probably always will be, unmet needs and unsolved, but not insoluble, problems—some new and some old. It is apparent that the responsibilities of the mental health societies are greater than ever before and that the need for closer coöperation and collaboration between the voluntary and official agencies—health, welfare, education—is likewise more important than ever before. In the words of Mr. Adlai Stevenson, then Governor of the State of Illinois:

> "We (the official and voluntary agencies) are in business together. We are partners in the sense that the care of the mentally ill is a joint enterprise between the agencies. It is recognized more and more that neither can do the job alone and that we cannot get the best results working separately."[1]

[1] See "The Partnership of Public and Private Agencies in the Field of Mental Hygiene," by Adlai E. Stevenson in MENTAL HYGIENE, Vol. XXXVI, No. 1, January, 1952.

A PSYCHOTHERAPEUTICALLY-ORIENTED COEDUCATIONAL PROGRAM FOR MENTALLY-RETARDED ADOLESCENTS IN A COMPREHENSIVE HIGH SCHOOL *

FREDERICK W. BROWN

Coördinator of Special Classes, Sewanhaka High School, Floral Park, New York [1]

THE need for this program was first brought to my attention about fifteen years ago by a little gray-haired woman whose many years of experience had earned her an enviable reputation as a teacher. As I entered the room, her eighth-grade pupils were hilariously enjoying the antics of two big boys who were bombarding each other from opposite sides of the room with paper airplanes.

"Those boys!" she exclaimed helplessly. "Can you stop them?"

"Sit down!" I growled, and the room grew quiet.

"Can't you do something to get them out of here?" she whispered. "They're feebleminded. John's nineteen and Joe's seventeen. They're usually good, but sometimes I can't do a thing with them. Lately they've been threatening to kiss me whenever I correct them. I'm terribly afraid of them—sex, you know."

"Why don't you threaten to kiss them?" I suggested. "You'd probably scare them to death."

"I'd die first!" was the horrified reply.

During the next few months, the elementary and high school principals worked out the plan for sending these and other overage mentally retarded children to the high school where, it was felt, they would be helped in many ways, while at the same time, the elementary schools would be relieved of the educational and disciplinary problems created by their pres-

* Presented at the meeting of the American Orthopsychiatric Association, Inc., New York City, March 11, 1954.

[1] The statements and opinions expressed in this paper are those of the author and do not necessarily reflect the views or policies of the school or its administrators.

ence there. It was believed that the participation of these children in the life of the 2,500 high school pupils (the enrollment is now 4,500) would improve their morale and social adjustment; the variety of academic, vocational and cultural opportunities of the high school would stimulate them to further learning, and the high school marking system, which is based on individual ability as revealed by I.Q., reading comprehension and physical competency, would relieve them of the frustrations of failure.

The elementary school principals selected the children on the basis of the following criteria: an I.Q. of 50 to 80, a chronological age of 15, and retardation of two or more years. Each child's school record, pertinent medical data, standardized test results, and teachers' comments on special abilities and disabilities, interests and talents accompanied the principal's recommendation.

The program was placed in the hands of the writer as coördinator, counselor, and teacher of special classes in English, social studies, arithmetic, and general science, on a level adjusted to individual abilities. The boys were given regular woodworking shop and the girls cooking and sewing in regular classes, and all were given gym daily unless medically excused.

Things ran smoothly, except for certain behavior anomalies, in all classes except the shop—the area in which we had anticipated the least difficulty. The trouble was caused by the so-called normal boys who called our boys offensive names, hurt them, hid their tools, and sometimes destroyed their work. After several of our more aggressive boys retaliated violently, with nearly disastrous results, it was decided that their presence was too great a hazard and a special shop was designed for them.

After two years of experimentation, the following four-year schedule was worked out and continues in force. It also includes a ten-minute homeroom period every day; gym daily, except in the third year where health is substituted; and one full-period a week for guidance.

First Year:—

2 periods of shop for boys and home economics for girls.
2 periods of class work for boys and girls together.
English and social studies are coördinated, emphasizing reading with understanding, where and how people live and earn a living, and how they are governed.

General science and arithmetic are coördinated, with emphasis on the practical uses of arithmetic and applications of scientific principles in every-day living.

Second Year:—

2 periods of shop and home economics.
1 period of English, emphasizing reading comprehension and composition.
1 period of social studies—world history.
1 elective.

Third Year:—

2 periods of shop and home economics or one of these and one elective.
1 period of English as above, with letter-writing added.
1 period of social studies—American history, emphasizing European backgrounds, international relations and current events.

Fourth Year:

Regular Senior homeroom.
1 period of English.
1 period of social studies—American history, emphasizing political development and democratic institutions.
2 or 3 electives.

The electives include: general mathematics, practical geometry, art, ceramics, music, earth science and agriculture. Also, each year, one or more of the older pupils passes the elective course in automobile driving and secures his license. Those who complete three years are placed in regular Senior homerooms, for they want to "belong" and, by this time, have achieved sufficient emotional stability to relate satisfactorily to the normal adolescents and their group activities. They may remain in the special classes in English and social studies if they wish, but most of them choose the regular classes.

Considerable difficulty was experienced in finding a teacher for the homeroom, first-year class work and shop, who had the necessary training, experience and skills in the manual arts and the attitudes essential to the success of the program. After several trials, the right man was found. In coöperation with the coördinator, he handles the scheduling and any special problems that may arise. An equally well-qualified woman teacher meets the second- and third-year pupils daily, as a group, for English; and I meet the same group daily for social studies. The services of our full-time school psychiatrist, psychologist, placement director, nurses, the speech and reading clinics, and the clinic for the hard-of-hearing are also available.

About 250 children have entered our program since it began. The number entering varies from year to year and so does the ratio of boys to girls and the number who graduate.

Roughly, about one-third complete the four years. Nearly all who drop out do so during the first or second year, in order to work. One or two move out of the district, and one or two others leave for health reasons. Our present enrollment is 29, of whom 15 are boys and 14 are girls. The classes average about 15 pupils.

Most of our children come from homes of low social and economic status. In more than half of them, the parents are foreign-born and are more or less dependent on charity or the earnings of their children. The low mentality of some of the parents and their lack of understanding of our language and customs makes it difficult to secure their coöperation, but most of them are very grateful and try to help. Five families have contributed two children each to our program; three have given us three each; four boys and a girl came from one family, and three boys and three girls from another. Eleven of our number have been from foster homes. Six have had brothers or sisters of average or superior ability who have graduated from high school.

All of the children who have entered the program may be classified psychobiologically into three main groups, two of which have two subdivisions:

I. Those who are physically healthy, but whose retardation is directly related to the innate biological defect commonly designated mental deficiency. They are about equally divided between:

A. Those who are quiet and friendly, and try to learn.

B. Those who are restless and hostile, and make no effort to learn.

II. Those whose retardation, personality, and behavior disorders are directly related to physical disease, defect or injury. They also fall into two sub-groups:

A. Those whose anomalies are sequelæ of brain injury or disease. They include one case of pituitary disorder; a hydrocephalic boy; six postencephalitic boys; two boys who had cerebrospinal meningitis; a boy and a girl with *petit mal* epilepsy; a girl with cerebral palsy with complications; two boys with birth injury; one who had brain fever; one with a brain abscess; two schizophrenic boys and a schizophrenic girl; and a psychopathic boy.

B. Those whose personality and behavior disorders are related to physical defects, injuries or diseases presumably not involving the brain tissues. These include a boy and a girl who had poliomyelitis; two boys with rheumatic fever; a boy with diabetes; four cardiac cases; three with hearing loss of more than fifty per cent; three boys who had lost the sight of one eye; and at least thirty children with uncared-for visual defects.

III. Those whose personality and behavior disorders are the result of unfavorable interpersonal relations, apparently without innate biological defect or physical disease, defect or injury.

My first year of working with these children provided abundant evidence that, while formal instruction had to be adapted to the intellectual needs of the individual child, the functioning of the program depended upon the handling of their emotional needs. In most cases the native ability was so overlaid with emotional problems that they, rather than low I.Q.'s, stood out clearly as the determining factors in retarding the learning process. Instead of an educational program, I found myself in charge of an experiment in group psychotherapy in an educational setting. This statement and what follows in no sense implies the assumption of the prerogatives of the psychiatrist. It is a matter-of-fact description of the imperative need to bring to bear all available knowledge of psychology and psychiatry on a practical educational problem.

Two questions immediately arose: (1) How can psychotherapy be applied to best advantage in this situation? and (2) What should be the attitudes of the teacher-therapist to insure maximum results?

The answer to the first question was provided by the principles and techniques described by Allen,[1] Sullivan [2] and Wile.[3] These children can be helped, in the classroom and in individual conferences, by means of a dynamic relationship between the teacher and the child, in which the child's inhibitions to satisfactory living (including learning) are eliminated

[1] See *Psychotherapy with Children*, by Frederick H. Allen. New York: W. W. Norton & Co., Inc., 1942.

[2] See *The Interpersonal Theory of Psychiatry*, by Harry Stack Sullivan. New York: W. W. Norton & Co., Inc., 1953.

[3] See *The Challenge of Childhood*, by Ira S. Wile. New York: Thomas Selzer, 1925.

or reduced through mutual recognition, analysis and understanding of his patterns of interpersonal relationship, and in which these patterns are reorganized in terms of immediate and more remote goals. The immediate goals are the development of a rational self-esteem and coöperation in the educational and social activities of the class and the school. The more remote goals are economic and social security, concretely expressed by the adolescent as a good job and a good time.

The general attitude of the therapist is described by Levine [1] in terms singularly appropriate to our program: "In general his response must be one of human friendship and warmth and reassurance, of providing a certain security and feeling of acceptance, which often acts as a force to lessen anxiety. The therapist must somehow put across to the patient the fact that he now provides a new potential source of strength. He must transmit to the patient the vital reassurance that an adult of some strength and experience will now try to help him solve some of the problems that have led to anxiety and that the therapist believes the patient to be capable of learning how to meet his conflicts and anxiety more adequately than before."

More specifically, the teacher-therapist, to be successful, should: [2]

1. Accept each child as a person—not as a moron, a nuisance or an epileptic; but as a feeling, thinking, hoping human being who, in spite of his handicaps, is potentially able to have confidence in himself, to learn by experience and to enjoy himself while learning.

[1] See "Principles of Psychiatric Treatment" by Maurice Levine, in *Dynamic Psychiatry*, Franz Alexander and Helen Ross, editors. Univ. of Chicago Press, 1952.

[2] I wish to express indebtedness for some of the ideas stated here to two psychiatric sources I have never seen in print. Among my notes is a 3 x 5 card, brown with age, on which I attribute the following remarks to Lawson G. Lowrey, date unknown: "The most difficult tasks of the therapist are (1) To accept the child at the level at which he is; if infantile, accept him at that level and try to learn why, (2) To accept his behavior at the level at which it is, whether it be stealing, lying, or what not, and try to learn why he behaves that way. (3) To recognize any personal prejudices and inhibitions in one's own approach to the problems of others (*e.g.* sex) and try to understand and eliminate these prejudices." The second source is my typewritten notes from a course in the correction of speech disorders, taught by Smiley Blanton in 1922, in which he points out that one of the most important factors in the treatment of stutterers is "the right bodily postures" of the therapist.

2. Accept the child at the level at which he is, and try to learn why. If mentally retarded, unable to read or write or do arithmetic; if he cannot pay attention or remember, try to learn why and do something about it.

3. Accept his behavior at the level at which it is. If he is timid or hostile, cries, swears or soils himself, try to learn why he behaves that way and do something about it.

4. Make every contact helpful to the child, not only in counseling but in the classroom and in informal situations, especially if he is in trouble.

5. Be acceptable to the child by communicating to him unequivocally the vital reassurance that he (the therapist) is free of prejudices and inhibitions in approaching his (the child's) problems. Just as a mother's anxieties, like her tender emotions, are communicated to the infant through muscle tensions that determine her posture, gestures, and facial expressions as well as the pitch, force, rhythm and quality of her voice, so are the attitudes of the therapist communicated to the child. His muscle tensions convey more powerfully than all his words his attitudes towards the child as a person, towards his defensive behavior and the anxiety that underlies it. They cannot be cold or neutral—such are the tensions of the dead. In the living, interpersonal relationship of psychotherapy, they reveal the therapist's understanding approval of constructive patterns and his equally understanding disapproval of patterns that are harmful. Only to the extent that his muscle tensions communicate attitudes that are realistic and unprejudiced will the teacher-therapist be acceptable to the child. In short, the *empathy* stressed by Sullivan as vital in the mother-child relationship is equally necessary to the security and self-esteem of the educationally handicapped child.

In applying this philosophy, our initial step is the orientation of each individual to the opportunities that lie before him. We want him to know what to expect of us and what we expect of him. At the beginning of each school year, each member of the entering class is interviewed by the school psychiatrist, who discusses with him his abilities, handicaps, interests and ambitions. During the first week, the coördinator talks to the group for the purpose of relieving them, as much as possible, of the special-class stigma which many of them feel

very keenly. They are assured that in the high school everyone follows a special program based on his abilities and planned to meet his needs, and that they have the same opportunities to complete the four-year course and receive the same diploma as any other pupil, and to take part in all the social and other activities that are available to all high school pupils. Emphasis is placed on the special preparation of their teachers to help children with their abilities to learn new things provided they are friendly, coöperate, and try to learn. During the regular and special homeroom-periods, the homeroom teacher explains their schedules and courses, the school marking system which makes it possible for every pupil to be marked according to his abilities and the effort he puts forth, administrative regulations with the reasons for them and the penalties for their violation, and the many regular and extra-curricular activities that are open to them.

Some of our problems may be seen more clearly in the light of the general characteristics of our three main groups and the specific behavior of some of the individuals in each group.

I. Most of the children in our first group, the mentally deficient, have learned to read and print a little before coming to us, but they have very little ability to recognize printed words or numbers or identify them with their spoken language, or to remember simple factual relationships or arithmetic processes from day to day. Their outstanding intellectual characteristic in relation to the learning process is their deficiency of visual and auditory memory. "Memory," according to Gerard,[1] "involves the making of an impression by experience, the retention of some record of this impression and the re-entry of this record into consciousness (or behavior) as recall and recognition . . . Without memory the past would vanish; intelligence, often called the ability to learn by experience, would be absent, and life would indeed be 'a tale told by an idiot, full of sound and fury, signifying nothing.'" To our mentally deficient children life is relatively empty of symbolic experiences, but relatively full of direct sensory impressions interpreted immediately in terms of the primitive pleasure-pain continuum.

A. Our friendly mentally-deficient children are extremely

[1] See "What is Memory?" by Ralph W. Gerard in *Scientific American*. 1953. 189: 118–126.

sensitive and insecure, and often cry when faced with a new problem. They need to be shown, in detail, what to do and, even then, frequently need reassurance. Most of them are girls who have been overprotected at home. Five have been foster children living in homes where real affection was shown them. Three have been from homes where they developed strong feelings of inferiority to brighter children.

Typical of this group were Ruth and Donald whose respective I.Q.'s were 61 and 50. Both were well-mannered and neat and were often disturbed by the ill-manners and carelessness of others. Ruth was a delicate little girl, whose eyes filled with tears in response to any task involving reading or writing. An encouraging word or gesture from the teacher and a personal demonstration of what was wanted usually brought a smile and eagerness to work that produced good results within the limits of her ability. Donald's highest achievement in reading and writing was the laborious copying of numbers and sentences in large printed characters. He was very proud of his notebooks, which he had kept ever since starting school. His shop work was limited to very simple construction and painting. His attempts at reading and writing were discontinued on advice of the school psychiatrist, who found that he mistakenly believed he was learning by these efforts, whereas he was only wasting time. He was a willing worker and, during his last two years, worked in the cafeteria half-time. He was much happier at this work than in the classroom, for he earned his lunches and was praised for his good work and dependability. Since graduation, he has been steadily employed, for a few months as a bus-boy in a large restaurant, and for more than a year painting toys.

B. The chief characteristic of our other mental defectives is hostility. Their attitude towards classroom procedures and school regulations appears at first to be deliberately defiant, but on closer scrutiny is seen to be one of almost total disregard. Authority is meaningless when in conflict with their desires of the moment, and behavior appropriate to satisfy these desires is uninhibited and immediate. When forced to comply, they sulk; often expressing their frustration by profane or obscene mumblings or by kicking or pushing the furniture and sometimes other children. They dis-

trust everyone who will not let them do what they want to do and they are in turn, extremely unreliable and unpredictable. Kanner[1] points out that the strongly rejected child, when he enters school, "has for six or more years lived in a hostile world . . ." and "unless he has been utterly crushed, he has learned to fit himself into the pattern through rebellious or sneaky aggressiveness." The home and school histories of our hostile children show that they have lived in a hostile world for more than fifteen years. Their environment has given them little in the way of affection and satisfaction but much privation, frustration and discouragement since the day they were born. "Rebellious and sneaky aggressiveness" are their chief modes of behavior.

This group is well illustrated by three boys and three girls from a family of fifteen children, nine of whom are living. Both parents were born in southern Europe of poor families and had no formal education. The father was irregularly employed as a laborer, and the family was on relief until the older children left school at the seventh or eighth grade and went to work. Between the births of her children the mother worked in a factory. None of the six children who came to us over a period of ten years made any effort to learn. They constantly annoyed others, frequently ran out of the classroom and sometimes away from school altogether, and were often truant. All left school to work as soon as they were sixteen. The girls, like their mother, have been steadily employed, but the boys have had many jobs and, like their father, cannot hold them.

Let us pause a moment to ask what these healthy mentally-deficient children get out of our program. Very little improvement is seen in their basic skills or memories, even though they remain four years. For the friendly ones, the program seems to have a qualitative value—their interests are broadened by contacts with new ideas and materials, and every little success brings them happiness. Their acceptance into the daily life of the high school gives them a feeling of security among their peers that is evident in their increased poise and self-confidence. For the hostile ones, we are too late. In a few instances, there have been momentary flashes of

[1] See *Child Psychiatry*, by Leo Kanner. Springfield, Ill.: Charles C. Thomas, 2nd edition, 1953, p. 135.

understanding and affection that lead one to hope that they might be helped, but it would require a much more intensive program of individual psychotherapy than we are prepared to offer. Every flash, however, is a "flash-back" to a host of lonely babies who could have grown into friendly adolescents in a more kindly world.

II. Our second major group is made up of children, nearly all of whom have had long periods of absence due to illness and this, in itself, has retarded them. Many are so unstable physically that any effort to concentrate for more than a few minutes at a task requiring reading, writing, or other hand-and-eye coördination results in spasticity or some other failure of normal functioning of the muscle groups involved. Most of them are so burdened with anxiety and lack of self-confidence that any task, but particularly a test situation, is confusing and frustrating and, with some, chronic hostility is an additional inhibiting factor. For these reasons, and also because most of these children have good memories and show good judgment and reasoning ability quite frequently, I question their I.Q.'s which range from 50 to nearly 90.

A. The behavior of our six postencephalitic boys was most consistent as well as most disturbing. All of them were extremely sensitive and frequently interpreted friendly words and gestures as a personal challenge, calling for sudden and violent outbursts of temper. They were often cruel and, with one exception, had almost no regard for social amenities or school regulations and rarely expressed regret or showed any signs of feelings of guilt. All of them, however, respected their teachers, sought their approval and looked to them in childlike dependence for understanding and help in time of trouble. None of them graduated but two of them did work comparable to that of the average high school student. The contrasting home backgrounds of these two boys are of special interest because of their apparent influence on the boys' personality and behavior.

Jack had certain character traits that were exceptional in our postencephalitic picture. He was usually friendly and coöperative and his progress in all subjects suggested much greater ability than his 65 I.Q. revealed. He wore a benign expression and his behavior was as angelic as his countenance, except when startled. If someone dropped a book, bumped

him, or pushed his chair, he flew into a violent rage, hitting the offender until forcibly restrained. He was the rare exception who expressed regret, and his "I'm sorry; I couldn't help it," was accepted even by those he hurt, as a statement of fact. After a year-and-a-half of high school he had a second attack of encephalitis, following pneumonia. I visited his home and believe I found there the secret of his basic gentleness in the patience and fortitude exhibited by his little English mother under almost unbelievably difficult circumstances. A rear hallway at the top of three flights of stairs comprised the curtained-off bathroom, dining-room, kitchen and the bedroom for the parents, while two small rooms served as bedrooms for the two daughters and three sons. The father, a burly English laborer, out of work at the time, and the mother greeted me. The mother took me at once to look at Jack, who was in the second week of his coma. Then she talked hopefully of his recovery while she prepared tea. As we sat at the small table, the 200-pound, 22-year-old imbecile son appeared in the doorway of the girls' room and began scolding his mother for giving me his cookies. She pushed him back gently, remarking as she closed the door, "He doesn't understand." While we talked, I felt something brush against my leg and thinking it a friendly dog I glanced down into the upturned drooling face of a fat vegetative idiot, the ten-year-old son, who had crawled from the other room and was pawing my foot. His mother guided him back without comment and spoke proudly of Helen, her younger daughter, who had an I.Q. in the 50's and, after a year in our program, was happily employed in a paper-box factory. On the way downstairs, I met the older daughter returning from work. She was a high school graduate of superior intelligence and held a good position as a stenographer. "I'm so glad you came," she said. "We feel we know you, for Jack and Helen have talked so much about you." Then, resignedly, "I don't know what happened—I guess I got all the brains of the family."

Ed was 19, had an I.Q. of 85 and studied hard. He was polite and courteous with the teachers, but fought with the boys at every opportunity and made himself obnoxious by his unnecessary display of contempt for the girls. He was obsessed with the idea that his father had murdered his

mother and had run away with a prostitute. He talked of revenge to anyone who would listen. One evening, two years after his mother's death, his father came to visit Ed at the home of his uncle and guardian, bringing a new wife with him. Ed was working at the time, and his father demanded half his earnings. Ed ran out of the house cursing them and, fortifying himself with whiskey, decided to kill them while they slept. Fortunately, he dropped by to tell me his plan and get my assurance that I would help him afterwards, for, he said, I knew "the old man had it coming." I agreed, reminding him that he had often said his father had driven him crazy and was responsible for his violent temper. Then I pointed out that, even if the court found that his father was to blame, it would decide that he was insane and lock him up in a mental hospital for the rest of his life. "God!" he exclaimed. "That's right. But what'll I do? If they're there when I get home I'll have to kill them." "That's easy," I said. "Phone your uncle to get them out of the house and to tell your father to keep away from you if he wants to live." He did, and they were gone when he got home. Ed's hostility towards his father may have been augmented by his encephalitis but, according to his uncle (the mother's brother) it had ample justification. His father, a chronic alcoholic, had for years beaten Ed and his mother and, while the mother lay dying of cancer, lived in his own home with the prostitute whom he had ostensibly hired to take care of his wife and son.

Our epileptic girl and boy, who were with us at different times, are of special interest because we were able to modify their *petit mal* attacks. Both had I.Q.'s in the low 70's, but were good readers and usually displayed good judgement and reasoning ability.

Mary was very active and attentive and had a happy disposition and an animated expression. Her attacks were preceded by an almost complete cessation of movement and loss of animation as she stared vacantly into space. I found that it was possible to forestall loss of consciousness and its aftermath of headache and nausea by gently arousing her interest and holding her attention until the premonitory signs disappeared.

John's attacks were preceded by several hours of restless

behavior, a sneering, contemptuous attitude towards his teachers and profane or obscene language addressed particularly towards girls. This was a period of elation in which he laughed boisterously at his own remarks but, neither at the time nor in conference later was he aware of the change in his usual pleasant, courteous manner. Distraction did not work with him, but taking him to the school nurse's office where he lay quietly on a cot until his mother came to take him home resulted in eliminating his loss of consciousness and falls at school, and his attacks became less frequent.

B. Outstanding among those whose physical disabilities presumably did not affect the brain tissues was Harry, who had diabetes. As long as he maintained the proper balance between his insulin and his diet he was a well-dressed, polite and friendly boy, and his oral reading ability would have been outstanding in any high school class. But when he yielded to the temptations of candy bars and cake, he became careless of his appearance, his manners and his work, and took special delight in verbally and physically abusing his "girl friend" who, normally, was the focus of his affection. He was arrogant and belligerent with students and teachers alike and his language was often profane and obscene. Most noticeable was his complete loss of oral reading ability; punctuation and meaning were ignored and he skipped or misread many simple words. We learned to utilize these signs as the basis for getting him to his doctor, but he was usually ill for several days. During his last year in school the girl friend often avoided his abuse and reduced the severity of his attacks by whispering to me, before the signs appeared, "He's been eating candy again."

Our cardiac cases, three boys and a girl, and our two boys with rheumatic fever have all had I.Q.'s in the high 70's or low 80's, have been able to read and write well, and have displayed many evidences of average or better mental ability. All of them, however, have been incapable of sustained mental effort and frequently refuse to work at all. Their anxiety in the face of school requirements often appears to be a consciously directed means of "getting away with" as little work as possible. They present a difficult problem for we do not know the extent to which their disabilities are real or

due to what Kanner[1] describes as of "iatrogenic (physician determined)" origin. I discuss their anxieties with them and their mothers with particular reference to their mental abilities and their future health and happiness. This has helped in some cases, notably that of the girl and two boys, who graduated and have made good economic and social adjustments, and one boy who is now in his third year and doing good work. The other two boys were withdrawn from school because "the work was too hard" and are loafing because their mothers are afraid to let them work. One of them recently visited the school in a state of mild intoxication, and is reported by boys who know him to have turned into a bum who sits in taverns every night drinking and boasting that he doesn't have to go to school or work.

Of particular interest are the thirty or more children with uncared-for visual defects. Most of them have learned to read and write at the third or fourth grade level, have recorded I.Q.'s in the 70's, "perfect vision," and school records of non-coöperation and aggressive misbehavior. They are convinced that they cannot learn from books because they are "dumb," and are actively hostile towards education in general and teachers in particular. Nearly every year, we manage to show one or more of these children that they cannot read because they do not see words and numbers as normal readers see them. With their help we get their parents to take them to an ophthalmologist whose examinations have never failed to reveal the suspected visual defects. Most of these children, after the defects have been corrected by glasses, increase their reading ability to nearly normal for their grade level, within a year or two, enter regular classes and graduate.

The most extensive improvement was shown by a girl whose reading level rose from fourth to eleventh grade in one year, whose I.Q. changed from 72 to 115, and who was on the honor roll during her last two years in high school.

The quickest and most complete personality change was that of Pat, a tough little Irish boy who could not (or would not) read at all. He was sullen and profane, never smiled except in derision, and went out of his way to quarrel with everyone, including me. He went to the ophthalmologist to

[1] See *Child Psychiatry*, by Leo Kanner. Springfield, Ill.: Charles C. Thomas, 2nd edition, 1953, p. 373.

prove that I was wrong. The examination showed severe astigmatism and myopia. With his new glasses and an hour a day in the reading clinic, Pat learned to read well within a year, but the greatest change was in his personality. A week after he began wearing glasses he was a laughing, friendly boy who was taking girls to the movies. He stopped after class one day to tell me, "I thought all the boys were crazy, raving about girls. They all looked like bags to me. But now! Gee, I never knew what a girl looked like till I got my glasses."

These visual defects escape detection in the lower grades through the misuse of Snellen type visual charts as the primary means of eye examination. Baker[1] points out that ". . . cases of hyperopia easily accommodate their visual adjustment to appear as having normal vision. The myopic child is sometimes able to strain his eyes for a few seconds to see the visual chart at the normal distance of 20 feet, but such a result does not prove that vision is normal or without strain in the practical seeing of daily tasks." The same holds true, he says, for astigmatism and nystagmus.

The histories of our children show that they are given Snellen tests in the third or fourth grade and are found to have "perfect vision." The experience of my son, who barely escaped their fate, is so pertinent that I want to review it. He, too, had perfect vision by the school standard. Therefore, in the third grade, when he said he could not copy the arithmetic homework from the blackboard because he could not see it and could not read from the readers because the words became blurred, his teacher and the principal called him a liar before his classmates, punished him in other ways, and when he got mad and "talked back" they sent him home as a bad boy. I was told that he could not return until I did something to make him behave. I did. I took him to an ophthalmologist who found that he had severe astigmatism complicated by myopia and he has worn strong glasses ever since. He has completed two years of college and the Army Signal Corps School with high ratings in electronics and mathematics, but I have no doubt whatever that, like Pat, he would have been *made* a retarded problem-child with a low

[1] See *Introduction to Exceptional Children*, by Henry J. Baker. New York: The Macmillan Co., Revised Edition, 1953, p. 35.

I.Q. had it not been that his irate father believed him when he said he could not see.

The children in our group are not so fortunate. Their parents are ignorant of such matters and have more faith in the schools than they do in their children where school work is concerned. They try to help the teachers by scolding and punishing their children, but when the children still refuse to read, the school suspects that they may be mentally deficient and gives them an intelligence test. In view of their actual defective vision and the anxiety and hostility engendered by teachers and parents it is remarkable that they achieve a 70 I.Q. But this settles the matter, for no one questions the I.Q. or tries to find out why it is low. Their egos suffer another blow when they are put in "opportunity" classes with children they know are really "dumb," and are told that, since they cannot read, their education, henceforth, will be confined largely to learning the manual arts. (I never cease to marvel at the naïveté of "educators" who assume that a mentally deficient child can learn to be a good carpenter or mechanic, seamstress or cook.) For the next few years they are passed along, accumulating more and more punishment, resentment and hostility, distrust of their elders and confusion with respect to their place in the world, until they come to us. And even at the high school level they go through a routine visual check with Snellen charts and still have "perfect vision." But their progress, when their vision is finally corrected, is a valid indication that much, if not all, of their retardation and social maladjustment was forced upon them by people, who mistrusted and mistreated them.

III. Our third major group consists largely of boys and girls who have been recognized as "problem children" from the time they entered school, or even before. The exceptions are those whose many changes of schools have resulted in their being left back, but they have similar problems. Most of these children have I.Q.'s in the 70's or low 80's and enter our program two or three years retarded. Nearly all of them come from homes where the emotional problems of their parents, externalized as alcoholism and quarreling, have filled the children with anxiety and insecurity. Often the European-born father tries to compensate for his insecurity by imposing an autocratic authority on his family, and the mother reacts

to her unsatisfied longings by heroic self-sacrifice or over-protection of her children. The result? No one loves anyone as well as he does himself and everyone is unhappy. These children have a common plea, "Why can't I have parents like other kids?" Usually during the first two years we are able to help them to a better understanding of their parents' problems and relieve some of their confusion with respect to their status at home and their growing need for independence.

Sometimes the classroom behavior of one of these children makes the need for psychiatric attention obvious. Such was the behavior of George, which seems to illustrate Sullivan's description [1] of an adolescent disturbance of personality on the threshold of schizophrenia. Sullivan calls it "the eruption into awareness of *abhorrent cravings* . . . the entrance into personal awareness of increasingly-intense-because-unsatisfied longings to engage in something which is abhorrent—that is, the picturing of engaging in it is attended by uncanny emotion such as horror, dread, loathing or the like."

George, an 18-year-old sophomore with an I.Q. of 71, hated the high school at first but, after several conferences in which his father's cruelty, the constant quarreling of his parents and the effects of these on his attitudes and behavior were frankly discussed, he settled down for a year of work with only an occasional outburst of hostility. Then the picture changed. He would suddenly jump up, in what can only be described as a state of terror, and disrupt the class with a loud denunciation, after which he would slump into his seat and be lost in reverie for the remainder of the period. These episodes for one week were as follows:

> *Monday.*—A boy opened a window and leaned out. George jumped up, pointed at him and screamed, "Look at the crazy fool! He's a fool!"
> *Tuesday.*—Pointing at a small Italian boy, he shouted, "Look at that dirty Guinea! What's he doing?" The boy was hidden from me and when I asked what he was doing he said "Nothing." Later I learned that he had been entertaining the boys around him by pretending to masturbate.
> *Wednesday.*—Beneath the classroom window several boys began yelling and laughing. George rushed wildly to the window, shouting "What was that?" As the noise continued and he got no answer he turned to me with a frenzied "What is it?"

[1] See *The Interpersonal Theory of Psychiatry*, by Harry Stack Sullivan. New York: W. W. Norton & Co., Inc., 1953, p. 326.

Thursday.—He jumped up, pointed at a girl in the front of the room and yelled, "Look at the dope! She ain't even opened her book. She just sits there looking at nothing!"

Friday.—I mentioned that as an ambulance driver in World War I I never shot at the enemy. George yelled at me, "Sissy! You never fired a gun! You never killed a German! You're a sissy!"

Each day he walked slowly past my desk after the others had gone and when I asked him what was the matter he would say, "I'm just nervous. I'm all right but everything makes me nervous, especially these kids." Friday, I said, "I made you nervous today. What's the matter? Haven't you been getting enough sleep?" He trembled violently and hung his head as he replied, "Oh, they're at it again—my parents—fighting and screaming all night—I can't sleep—I'm afraid." After a few minutes talk, he willingly accepted my suggestion that the psychiatrist might help him get hold of himself. Several interviews with her reduced his anxiety and brought an end, at least temporarily, to his outbursts.

Put five or six children from each of our major groups into a classroom and the variety of interpersonal reactions and behavior deviations from normal expectancy beggars the imagination. Our most unusual combination of personalities was a class that contained, among others, three postencephalitic boys, a psychopathic boy, a hydrocephalic boy, two extremely hostile girls and May, a quiet, hard-working girl with a well-earned reputation for promiscuity.

Almost anything may happen in such a class, and when it does the teacher must act quickly to prevent bedlam or physical violence from destroying the essential unity of the group. One day as I entered the classroom May was in the middle of the floor screaming "Dirty liar!" and "I'll kill you!" at three big boys who were unsuccessfully trying to ward off her kicks and blows. Laying a restraining hand on her arm, I asked, "What's the matter?"

"Get them out of here! I'll kill them! They called me a dirty whore!" she cried.

"She is!" they chorused. "She lays every boy in town!"

"Did she ever lay you, or you, or you?" I asked, pointing at each of them in turn.

The surprised answer of each was an emphatic "No!"

"Well, then," I said, "you're falsely accusing her. You

have no real evidence, only rumor and gossip, like a bunch of old women. But even if she were what you called her you have violated the school code of good behavior by calling names and using obscene language. You know the penalty—a week's detention. Come along to the principal's office and take your medicine." Protesting, they followed me out of the room.

The next day May was absent and one of the girls asked me to let the boys go to the playground as they had something important to ask me. When the boys were gone, she said, "We like May, but what the boys said is true. Why is she like that?" They would not do such things, they said, for fear of pregnancy, social disapproval, and God's punishment, but May was not afraid. I told them I had talked to May about it and could answer their questions in the light of her family background and need for affection. Her father was a laborer, who gambled away most of his earnings, and her mother worked in a factory when not having babies. May was a well-developed girl of 17 with an I.Q. of 71. She had been left back three times in elementary school, because of prolonged absences while she took care of her ever-pregnant mother and seven younger children. Her promiscuity, I believed, was her way of satisfying her need for the kind of intimate, physical affection she had been forced to give her mother's children but had never received herself. She did have the same fears as the other girls but her need for affection was so strong and the pleasures of sex were so satisfying that they easily overcame the inhibitions imposed by her limited intelligence.

On another occasion, Pat, our tough Irish boy, and Alice, the most hostile and profane girl we ever had, were the central actors in a scene that called for quick interpretation. Alice entered the room a few minutes late and as she passed Pat, who sat in the front seat, he kicked her in the shins. With a well-aimed right to the eye and a short left to the nose, accompanied by a blistering string of profanity, she knocked him out of his seat. For a moment the class was speechless as she walked back to her seat and Pat, his head bloody and bowed, climbed into his. Then the boys got their breath. "Are you going to let her get away with that?" they shouted. "You wouldn't let us get away with cursing.

What are you going to do with her?" Alice spoke up, "I know! I'll get sent home like I have from all the other schools, but I don't care. He can't kick me!" I explained that I had seen the whole affair, which happened in front of my desk, and asked, "What would you do if a guy kicked you in the shins?" They agreed that they would kill him, or try to. "Would you swear at him?" "Yes, but she's a girl, and girls shouldn't curse." "Where did she learn those words?" I asked, and when there was no answer, I continued, "From guys like you and Pat who picked on her. She's had to fight guys like you all her life and she uses your own language and weapons." Turning to Pat, whose eye was fast closing and whose nose was still bleeding, I said, "Looks like she did a pretty good job. Will one of you boys take him to the nurse?" "I ain't going to the nurse and have to tell her a girl hit me," said Pat. "Let me go to the boys' room and wash up. I didn't go to kick her anyway. I just wanted to trip her." Everyone laughed and the incident was closed except for the kidding Pat got till his shiner healed.

But, a word about Alice. Like Pat, she came to the high school with a history of "perfect vision," but it seems incredible that her visual defect was never detected, for her nystagmus was so severe that her eyeballs literally floated in their sockets and could be brought to a focus only for a few moments at a time. The people and artifacts of her world were entirely different than they were described to her. She accepted the evidences of her own eyes and hated the people who, she believed, tried to deceive her. Her parents were very poor and as soon as we were able to get her proper glasses she left school and went to work.

In spite of the daily interruptions due to the perpetual insecurity and hostility of the children, the class work goes on. Our most effective means of restoring control of individual and group behavior is by appeal to two of the adolescent's major drives—his striving for personal maturity and his group consciousness. Even the violent physical conflicts, embellished with profanity, between two post-encephalitic boys are brought to a sudden end when the teacher calmly but firmly labels the behavior immature and uncoöperative, and gives specific reasons for his judgement. The reasons are all important for the adolescent demands concrete facts, or well-

authenticated beliefs, on which to base his behavior. He may argue with you, but when his group accepts your reasoning, he slips quietly into his place as a member of the group. Before work can be resumed, however, the anxiety and excitement must be supplanted by more pleasant emotions. A humorous anecdote or a teasing remark usually does the trick. It puts the group in a good humor and gives ego support to the offender who, invariably, labels the teacher's joke "corny."

The interests of these children and their desire for knowledge that will help them understand the world they live in differ in no way from those of their less-handicapped schoolmates. In the social studies classes, they learn how people have lived since history began, and are given the opportunity to clear up many misconceptions and prejudices, especially with respect to racial and religious differences. For example, in spite of the use of both the Old and New Testaments in Christian churches, these children, like most adolescents, are unaware of the relation of Christianity to the Hebrew religion and are astonished to learn that Christ was a Jew. As one boy put it, "The book is wrong. Jesus couldn't be a Jew. His mother was the Virgin Mary, and she was a Christian."

The social studies classes also provide an open forum for the discussion of topics of current interest from the daily press, radio, TV and individual experiences introduced by members of the class. The Christine Jorgensen story was followed with great interest and formed the basis for serious discussion of many questions concerning sex differences and hermaphroditism. Similarly, a news item with photographs of a two-headed baby led to the discussion of intrauterine life and normal, as well as pathological, prenatal development. Several of the children spoke of their own prenatal and birth injuries, and the fact that such a baby had been born made the physical defects and differences in mental abilities of the members of our group more understandable.

Occasionally a topic comes up that seems far removed from the field of social studies. Recently the class began with a request that we talk about blood. A boy wanted to know what were the chances of a child being black or white if one of his ancestors were a Negro and all others were white. The misconception that blood is the carrier of racial and

acquired characteristics was shared by all members of the class. This was cleared up, and the true function of the blood circulation as the main transportation system of the body was presented. Genes and chromosomes were introduced as the transmitters of inheritance and the session ended with a discussion of hemophilia brought up by another student. But, you may ask, are chromosomes and hemophilia fit topics for mental defectives? The answer is, "Yes." In addition to clearing up misconceptions and adding new words to the vocabulary, the subjects are of vital practical importance. The soldier brother of the boy who asked to discuss blood had received a transfusion from a Negro buddy. Now he has Negro blood in his veins. What are the chances of his children being black or white? Our one Negro boy remarked gleefully, "My blood's as red as yours." And Susie, our extremely spastic girl expressed great relief on learning that her children would not necessarily inherit her handicaps. When I suggested that if she should marry me we would have beautiful healthy children she quickly rejoined, "I hope they have your brains."

Fifteen years of association with these children has taught me many things, but outstanding is the fact that their intellectual functioning has been seriously and, for the most part, permanently retarded by the mistakes of their elders at home and at school.

I have questioned the validity of their I.Q.'s for three reasons: First, because I have found that emotional disturbances and physical defects have been the chief obstacles to their school progress; Second, because little consideration has been given to the influences of these defects and disturbances on the children's test performances, and Third, because many of the children show unmistakable evidences of memory, judgement, and reasoning ability far above their recorded I.Q. level, even before the physical defects are corrected or the emotional inhibitions reduced.

Strecker, Ebaugh and Ewalt[1] say that "a quantitative estimation of the intelligence is to be considered as adequate only when given under optimal conditions. Poor rapport, physical distress, fear, environmental disturbances are com-

[1] See *Practical Clinical Psychiatry*, by E. A. Strecker, F. G. Ebaugh and J. R. Ewalt. New York: The Blakiston Co., 7th edition, 1951, p. 44.

mon vitiating factors. . . ." Kanner[1] quotes Moore: "Home organization may be a factor not only in peace and happiness, and emotional stability, but also in intellectual development. . . . Normal mental growth is inhibited by years of unkind treatment of the child, whose fundamental craving is a point of fixation for its affections." Kanner continues, "The profound emotional difficulties which lead to the withdrawal of children with schizophrenia and early infantile autism have often masked good 'natural endowment' to such an extent that the children were frequently misdiagnosed as being feebleminded."

My own experience in administering thousands of intelligence, aptitude, achievement, and personality tests not only confirms these findings but adds to them the fact that the optimum conclusion one can safely draw from any test result is that it represents a sampling of the best the child can do under existing conditions of physical and mental health, mood, fatigue, and distraction. Even when unfavorable conditions are not apparent, marked discrepancies between test results and known achievement call for investigation and, usually, re-testing. I well recall administering a battery of three standardized tests of intelligence, silent reading ability and personality adjustment to a graduating class of about 100 eighth-graders. The test results were to be used, along with their final examination marks and interviews with parents, as the basis for their four-year high school program. The results were so out of line with the children's school achievement records that I asked the principal what could have happened. His reply was, "Your tests are no good." I put the same question to the mother of the class valedictorian who had averaged 99 in her final examinations, but was below average on my intelligence and reading tests. She solved the problem. The night before these children took my tests they had attended their graduation party (the principal was there, too), dancing all evening and ending with a midnight supper. Most of them had had less than half their usual amount of sleep. Upon the examiner's evaluation of such influences on the test results, especially in the lower grades, the future of the child often depends, yet they are disregarded by many "mental

[1] See *Child Psychiatry*, by Leo Kanner. Springfield, Ill.: Charles C. Thomas, 1953, p. 67.

testers'' and ''educators'' and are deliberately ignored by others.

Looking at the results of our program we see many evidences that our approach, with its emphasis on the ''Why?'' of human behavior, has enabled us to loosen the shackles of many of our children and help them to develop more efficient patterns of learning and living. But no matter how good the results, the program is still remedial—an effort to undo the results of years of misunderstanding and mistreatment.

Of far greater value would be a program that would prevent most of these children from becoming retarded, and help others to make full use of their limited endowments. A child guidance clinic, with a consulting ophthalmologist, in full coöperation with the schools would accomplish this end. At the same time, it would render a much-needed service to the many emotionally-maladjusted children who drop out of school at the seventh- and eighth-grade levels and the large group of children who are not retarded in grade for age placement, but who come to the high school so emotionally disturbed that their work is far below their potential level of achievement. These latter children are the source of most of the disciplinary problems of the secondary schools.

If the children in our program are typical of the country as a whole (and there are many evidences for believing that they are), it may be conservatively estimated that at least half of the adolescents in the country who are labeled retarded or mentally deficient would not have been so designated if they had had the services of a child guidance clinic at the beginning of their school life. And, in the light of other data, the same conclusion may be drawn with respect to the emotionally maladjusted children who constitute our major educational and social problems.

To all who believe that every child in our land of free enterprise and opportunity is entitled to the pursuit of an education unimpeded by preventable handicaps, these conclusions stand as a challenge to thought and action.

THE BEST OF LIFE IN EARLY CHILDHOOD *

GLADYS GARDNER JENKINS

Parent Group Leader, Bethesda, Maryland

AT no period in life is the influence of the parent upon health and happiness as important as it is during the first six or seven years. A parent is always an important factor in the life of a child, but as a child gets older he has greater opportunity to turn toward other adults and toward those of his peer group for satisfactions which he may not find within his family. The young child is limited primarily to the family group for his first contacts and experiences with life. They are the people who make up his world. The little child cannot take care of himself. He is dependent upon his parents to provide for him the opportunities for the kind of experiences which he needs for happy, healthy living.

These are the years, too, in which a child is absorbing into himself the pattern of behavior which the culture in which he lives sets as desirable. It is his parents who present this pattern to him, with expectations that he will conform to it. They are distressed if he does not do so. The way in which this pattern is presented, and the way in which it is enforced, will determine in part whether these years of early childhood are happy ones or whether they are filled with too much pressure and a resulting bewilderment and tension.

There are three things which little children need from their parents if they are to have the best of life in early childhood. First comes the need for emotional security, for a sense of being loved and valued. This involves the feeling of belonging to the family group, the realization that there is someone to turn to, someone to depend on.

The second is room to grow. The child who is hedged in with too many restrictions must struggle in order to grow. A child needs an understanding and sympathetic attitude as he tries to make his own choices and to do things for himself

* Presented at the annual meeting of the National Association for Mental Health, New York City, October 23, 1954.

and by himself. Without this kind of living space, provided by understanding adults, he is pushed either into complete dependence, at the time when he is trying to develop some individuality and initiative, or into overt rebellion.

The third is some framework of training and of guidance which, hopefully, is both consistent and appropriate.

Most parents are eager to fill these needs of their children, but sometimes they do not know how to do so. If we, in our mental health associations, can find ways to help parents to increase their understanding of children we can help to make the earlier years a better foundation for later growth.

We must recognize in the beginning, however, that if parents do not really love their children education will never make them do so. If they are capable of love, but are still too immature for real parental feeling, therapy may help them or their children. But it is not within the power of education to develop parental feelings where they do not exist.

The fact remains that there are many parents who have adequate parental feeling but who, because of lack of understanding or "know-how," do not succeed in getting that fact over to their children. The classical example is that of the first child who feels rejected when the new baby arrives and is the center of attention. When the older child reacts badly and is punished, he may feel that his first suspicions are confirmed: "Mother and Daddy love the baby best. They don't want me any more." As a result a cycle of interaction may begin between the parents and the child which is difficult and trying to correct. Such a cycle might have been prevented in some measure by education which would have given to the parents some insight into the feelings of a child placed in such a situation. Although jealousy could not have been prevented, if the parents had been aware of the needs of the older child, the intensity could have been lessened and the needs of the older child could have been more fully met.

It is also true that warm parental feelings are by no means always enough. Parents who love their children and can express their love may create situations out of which tensions may arise because they may have no conception of what to expect of a two-year-old, or no conception of how to show respect for a child's feelings while holding him to necessary requirements. As a result, battles of wills often develop which

might have been avoided if the parents had known what it was reasonable to expect.

It has recently become popular to discount the value of parent education because it is not likely to solve the problems of disturbed parents who need personal counseling and therapy. This is like discounting health education because it does not cure heart disease or tuberculosis, or discounting education in dental hygiene because it does not cure toothache.

Nothing is more characteristic of human beings than their capacity to profit by education. Parents are no exception. It is important to clearly distinguish the need for education, which is a general human need, from the need for therapy, which is a special need for corrective measures. There is a general need for parent education, for normally adjusted parents need information about children and can profit by help in developing a democratic family philosophy. There is more limited need for therapy. The two should not be confused.

Sometimes we fail in parent education and tend to discount its value, not because we do not basically believe in education, but because our methods are still poor. Sometimes we offer to parents materials for which they are not yet ready. We give a graduate course in emotional problems of family life before we have given an elementary education in the simpler problems of every day living together, or an understanding of some of the helpful factual material about children which many parents do not know. Many parents, for instance, still believe that all children (except the grossly retarded) can achieve the same goal if they only work hard enough. Many believe that a child has temper tantrums because he is "bad," and they must punish him into "goodness." The idea that a temper tantrum may be the child's way of expressing feelings for which he has no words is new to many parents. It is often wise and profitable to be willing to begin with the less complex problems which face parents, and then later try to give some understanding of the more involved relationships.

As mental health associations, there is a challenge to us to survey the field, and to think more deeply and reach for greater clearness concerning parents' needs for education. We need to give more thought to the kind of programs which we plan for parents. Picking a film off a list and choosing

someone with an outstanding name to discuss it, is not always the answer. Sometimes, indeed, such an approach forms a threat to parents rather than a help. The selection of materials, programs, and especially leaders demands a good deal of thought and consideration. It is an area in which we might well take leadership, for the demand for such help on the part of parents is steadily growing. Somebody is going to supply the demand, and it is important that standards should be developed.

Another area for our consideration is that of family-life education at the high school level. It is here that the largest number of future parents can be reached at a time when they are moving toward maturity. Too often we are only able to reach parents who are deeply disturbed or those who are voluntarily interested in obtaining increased understanding of their families. We should give serious thought to the kind of family-life education which might be offered in our communities at the senior high level—perhaps through the schools, the churches, the youth organizations. These young people will become parents within a few years. What can they learn now which will help them to understand children better when they establish their own families?

We might also consider what our rôle should be in encouraging the establishment of good nursery schools under adequate supervision, so that nursery schools might be available for more children in our community. Such schools can provide a little child with an environment in which it is safe to explore, to try oneself out, to learn how to get along with other children in an atmosphere which is freer of inhibiting restraints than the usual household or neighborhood environment. Such nursery schools can be used not only for the benefit of the children, but also for the practical education in understanding little children, which such schools can simultaneously offer to the parents. Our mental health associations might be able to coöperate with such schools by offering some of their program and leadership facilities for good parent education.

In many of our communities, there are also opportunities, which we might stand behind and encourage, for reaching parents through the pre-natal and well-baby clinics, through discussion groups sponsored by family service agencies,

P.T.A.'s, churches and other community groups. The field is wide open. But it is wide open to poor parent-education, as well as to that which is valuable. Perhaps our peculiar function is to work for guiding standards, and to show the way by offering resources to community agencies in the way of qualified leaders and well-chosen program materials and suggestions. We must also constantly emphasize that this is a comparatively new field, in which it is imperative that all who are involved should continue to evaluate while trying to develop better ways of educating parents.

Our goals, however, would be one-sided if we did not also continue our efforts to establish adequate clinical facilities in our communities which will provide therapeutic help for those parents and children who need it. The need has outrun our facilities, as we well know. Most of our clinics have disappointingly long waits for parents who turn to them for help. Sometimes, when a parent's turn arrives, the optimum point of receptivity to help has been passed; sometimes a parent has become discouraged and turned away.

We need perhaps, too, to think in terms of a different kind of counseling service for parents. There are many normally healthy parents who become confused by the daily problems of family life. They need to sit down with someone who can help them to gain perspective, to think the situation through, and to meet it themselves in their own best possible way. Such parents have perhaps got off to a bad start with one of their children or with each other. With a little help and supportive encouragement, they are able to meet their problem and adjust the family situation quite effectively. Such parents often do not need psychiatric help from our overburdened psychiatrists, but do need the guidance of those who are trained to understand the often frustrating and confusing problems of everyday family life, and to have the awareness of when the problem is of sufficient depth to indicate that psychiatric help is needed. We have not yet done enough in this area.

A mental health association in a community might, then, work toward sponsoring or encouraging a three-fold program:

1. Education for normal parents in group settings.
2. Counseling for normal but uncertain and confused parents who need individual help.

3. Therapy, either individual or group, for those parents and children who have deeper emotional reasons for their problems.

Our mental health associations are well-fitted to encourage in such ways as these the spread of wider and better-planned opportunities for parents to gain greater knowledge and understanding of the needs of little children, so that they will be better able to provide for their children those experiences in growing-up which will give them the best of life at its very beginning.

TWO RÔLE-PLAYING METHODS OF USING MENTAL-HEALTH FILMS AND PLAYS

WILLIAM GRAY HOLLISTER, M.D., M.P.H.

Regional Mental Health Consultant, U. S. Public Health Service, Region IV, Atlanta, Georgia

GRANT W. HUSBAND

Associate Director, Mental Health Association of Southeastern Pennsylvania, Philadelphia, Pennsylvania

SINCE participation by the student in the learning process has been demonstrated to enhance his learning, the development of effective audience-participation techniques in the use of films and plays deserves consideration as a way of improving group mental-health education. Malamud,[1] Nichtenhauser *et al.*,[2] Prados,[3] and others have recently reported experiences on the use of films in mental-health activities. The methods reported here have been progressively refined and field-tested over the last three years in the mental-health programs of Georgia, South Carolina, Alabama, and Tennessee. They are (1) the "feeling with or identification" technique, and (2) the "helping group" technique.

Both methods involve the audience in rôle-playing designed to give them a personal experience that they can use as a basis for better understanding of the principles of mental health. Our observations of individuals involved in these personal experiences lead us to feel that these two methods have also an attitude-building potential.

The "Feeling With" Method

The Audience-Preparation Phase.—Assuming that the film-showing mechanics and preview preparation of the leader have been completed, the audience is told the name, author,

[1] See "The Use of Films in Community Education," by Irene T. Malamud. *Journal of Psychiatric Social Work*, Vol. 22, No. 2, January, 1953, pp. 104–109.

[2] See *Films in Psychiatry, Psychology and Mental Health*, by Adolf Nichtenhauser *et al.* New York: Health Education Council, 1953. 269 pp.

[3] See "The Use of Films in Psychotherapy," by Miguel Prados. *American Journal of Orthopsychiatry*, Vol. 21, pp. 36–46, January, 1951.

and sponsors of the film or play in question. The leader then briefly paints a verbal picture of the setting and the names of the characters. The audience is then invited to share the forthcoming experience of these actors by "living the experience with them," "seeing it through their eyes," and "stepping into their shoes to get a sense of what is going on inside the other person." This is an attempt to help them experience, in part, the emotional forces at work in other people.

The leader then groups the audience into subgroups to identify with the principal characters—*e.g.*, one subgroup "to feel with the mother," another "actually to be one with the father"—so that each audience member is sensitized to pay particular attention to the experience of one character. In the case of a play, it is often possible to introduce each character before the curtain, so that each subgroup can become acquainted with the character with whom they are to identify. Often it is possible further to support the rôle identification by the suggestion, "You mothers see if you can sense how the mother feels about the father, about Aunt Susan, about the baby. Sometimes you can sense real differences between what she says and does and what she really feels about it. You are this mother. What happens to you as you live through this situation?"

The film or play is then presented in the usual fashion. We have especially used the films *Palmour Street, Fears of Children,* and *Preface to a Life* for these experiences, but we think that many others can be readily used. The *Temperate Zone* plays by Nora Stirling, published by The National Association for Mental Health, also lend themselves readily to this method.

The "Buzz Session" Phase.—As soon as the showing of the film or play is over, the leader invites the "mothers," "fathers," "Aunt Susie's," and other subgroups to get together for five or ten minutes, to share the individual and collective feelings they have experienced in their rôles. They are encouraged to compare reactions, to see how many *different* feelings they experienced, and to talk about their characters' attitudes toward the others in the film or play. This sharing seems to deepen and extend the perception of the subgroup to the person they are "feeling with." Often it is advisable

to have a subgroup leader help the group with the mechanics of participation, so that all may have a chance to share their subjective preceptions.

In some instances—especially in conferences where ease of participation and acquaintance with rôle-playing have already been established—this phase can be omitted and the next phase be introduced immediately.

The Interviewing Phase.—The leader requests the total group to re-assemble, and he reëstablishes the rôle each group portrays by addressing them by the name of the character with whom they are identifying— "Mothers," "Dads," and so on. The interviewing is opened by the leader's saying, "I'd like to ask each of you a few questions. Any one in your group can reply because you are really just one person. When you answer, feel free to say 'I.' For instance, 'I feel so and so,' or, 'I think that so and so.' Try actually to speak as if you were the person you are 'feeling with.' "

By a series of questions directed at the various "character" subgroups, the pattern of participation is started. In an attempt to create the impression that the action is still taking place, questions of the following nature are used: "Dad, how do you feel about what happened? Did you feel that the others really understood you? What feeling went through you when 'Mr. X.' criticized you? What did you really want to do at that point?" Occasionally it is necessary to encourage the group by saying, "Any one of you can speak. It's all right to differ. Anything you can say will be helpful in getting us to understand how people react."

Frequently, in the first few reactions, there is a tendency to intellectualize or theorize in the third person. Sometimes it is then necessary for the leader to encourage use of the first person and to keep the group on the level of emotional understanding by asking, "Could you say, '*I* felt so and so'?", or, "Can you say that just as if you were the mother saying it?" In our experiences the audience has readily adopted the first person and responded to the interviewer's questions.

The Interaction Phase.—Once the pattern of response to questions is established, the leader can then set the stage for the interaction phase that follows by asking questions that call for reactions about the other characters. "Mother, how did

you feel about Dad when he came home mad?" After a response to this, the leader turns to the "Dads" group and asks, "Did she understand why you were mad?" or, "What do you think about her reactions to you?"

It is usually possible to build up an interplay of responses back and forth between the subgroups. Frequently this progresses to the point where members of the two groups begin to face each other and respond directly to one another. Occasionally the leader can direct bids (as the situation indicates) to another character to join the talk. "Do you think Mother and Dad see your side of it?" We have seen the process proceed to the point where it continues so spontaneously that the leader can retire and sit down. Usually, however, his occasional participation is helpful to enable minorities to share, to protect their right to see things differently. It seems to be important to end this procedure once it shows signs of waning interest or of being played out, and to recapture audience interest by introducing the summarization process.

The Summarization Phase.—Several patterns of summarization have been explored: (1) the use of "buzz groups" to identify three or four of the principal points that have been learned from the presentation, which are then shared in a report session with the total group; (2) the use of a resource person to identify what has been learned or to provide interpretation; (3) the use of an evaluation discussion led by the interviewer-leader.

In this last plan, the leader turns the audience's efforts toward the question, "What steps can be taken to better these relationships?" The "Mothers," "Dads" and others can be asked, "What common daily little things that can be done in the home do you think might help?", "Where do you think you could do?"

We have found that audiences seem to respond with considerable interest when they have an opportunity to live through another person's experience with safety and the subsequent freedom it gives them to express their feelings about it with considerable intensity. Many feelings and emotional understandings that are perceived in conflict situations seem to emerge in a positive way through the use of this audience-participation technique.

Subjective evaluations of these experiences both in single programs and in conference settings have yielded high post-meeting reaction-sheet scores. Participants particularly comment on the "practicality of learning the actual verbal skill of talking about and communicating the way one feels to other people, the value of finding in these experiences an increased understanding of another person, another sex or family rôle, the growth in sensitivity to feelings," and "the chance to perceive the wide variety of feelings and reactions different people have in the same situations."

Although it is most probable that audience members project a great deal of their own dynamics into the rôle-playing, we have yet to experience an unfavorable reaction to this. It is quite possible that the evasion method or technique of hiding behind a rôle "that is not exactly me," and the social-standard pressures at work in the group, tend to minimize extreme reactions and to help the group to have a positive experience.

The "Helping Group" Technique

This technique can perhaps be best described by an example. The method has been used with the film, *Fears of Children*. The following brief five-minute sequence from the middle of the film was chosen for presentation.

> Two mothers are shown walking along the street, preceded by their respective sons on tricycles. The boys speed ahead and leave their tricycles to explore a cave in a pile of rocks. One boy experiences fear of the cave's darkness and cries out. The mothers run to the rescue, and the mother of the frightened child displays a questionable form of solicitude or protectiveness. Concerned by this behavior, the second mother invites the fearful boy's mother to coffee. In the absence of the boys, she begins to talk in a helpful way with the oversolicitous mother. (Turn off film here.)

After the film title has been announced, the leader informs the group that a brief excerpt from the film has been chosen for study. He sketches briefly the plot of the sequence, as outlined above, and tells the group that the film will be "cut" right at the point where the helpful mother begins to talk with the mother of the fearful son. He explains that when the lights come on, he (or some other rôle-player) will be seated in a chair before the screen, ready to play the rôle of the mother of the fearful son, ready to receive help. (A semicir-

cular audience seating and a chair for the rôle-player near the screen are helpful.) He then asks all of the audience to identify with the helping mother during the showing, to feel with her and to sense her concern. Then, when the lights go on, all of them as a group can play the rôle of the second mother and carry the coffee-table conversation right on with the mother of the fearful child.

The film sequence is then shown, and the moment it is ended the lights come on and the rôle-player is in place. He picks up and repeats one or two of the last lines spoken by his counterpart in the film and asks, "What would you do with a child like that?" Usually members of the audience quickly pick up and carry on the helping rôle that had been established in the film by the second mother.

Occasionally the rôle-player will have to stimulate response with "I've tried to do the right things. Why is he so afraid?" "Can you give me any idea of what to do?" If the rôle-player has been previously "loaded" with additional lines, he or she can keep the conversation going with such responses as "Aren't you afraid of your boy's getting hurt?" "Haven't you had a problem like mine?" "I've told him it's foolish to be afraid, but he still stays afraid."

In our experience to date, a rather lively interaction emerges, with many people taking turns in the helping process. After this has passed its peak of interest and participation has been widely shared, we feel it is wise to "cut" the rôle-playing and initiate a discussion. By stimulating questions, questions that bid for audience perceptions, the following topics frequently arise for discussion: fears and their causes, the feelings involved in a relationship, the helping process, the limitations of advice-giving, the values and disadvantages of reassurances, community resources for counseling, the way to interpret the use of mental-health facilities without offending, and the way to refer parents for child-guidance counseling.

Usually a strong request to see the entire film follows the discussion. When it is shown in its entirety, we have observed an immediate burst of conversation at the end. Once they have participated in the group discussion and formed their own image of the helping process needed, some audience members are quick to comment on the procedure shown in the film and to suggest alternative patterns of management. One

becomes aware that the group has become tremendously sensitized to an intensive level of listening and viewing by the rôle-playing experience. We have observed that only 10 to 20 per cent of the group do not participate in the rôle-playing at a verbal level.

At present we are experimenting with other rôle-playing devices to augment the learning experience with a film or play. A group of five-minute films are being developed especially designed so that several rôles can be set up ahead of showing and then immediately continued in a sociodrama at the film's end. We hope to report our experiences with these in the future.

THROUGH THE PATIENT'S EYES*

HOSPITAL-PATIENT ATTITUDES

LEE G. SEWALL, M.D.

Manager of Veterans Administration Hospital, Downey, Illinois; Assistant Professor in Nervous and Mental Diseases, Northwestern University

JOHN GILLIN, PH.D.

Professor of Anthropology and Research, University of North Carolina

FRANK M. LE BAR, PH.D.

Research Associate in Anthropology, Yale University

THE factors that influence the development and course of mental illness have been classified by one authority[1] as predisposing, precipitating, and perpetuating. Little can be done in adult life to modify predisposing factors. Precipitating factors are ordinarily of brief duration. The major problem in the treatment of emotional disorders, therefore, is dealing with those factors that influence the course of mental illness—the perpetuating factors.

In the hospital management of psychiatric illnesses, especially those of a more chronic nature, many patients improve to the point of a "good hospital adjustment," but fail repeatedly in attempts to return to community living. This raises the question whether hospital treatment programs contribute to the perpetuation of mental illness. In many cases, adaptation to the hospital environment or culture seems satisfactory. In what way, then, is the hospital situation different from community culture? There are a number of obvious answers, though much has been written regarding techniques of approximating the "community" within the psychiatric hospital. What is the patient's point of view?

For some time one of the present authors[2] has been plagued with the feeling that too many hospital programs are staff-

* We wish to acknowledge the valuable assistance of Dr. Henry A. Davidson, Cedar Grove, New Jersey, and Dr. Jules H. Masserman, Chicago, Illinois, in the editing of this paper.

[1] Dr. Nolan D. C. Lewis, in an oral communication, Downey, Illinois, February 25, 1953.

[2] Lee G. Sewall.

centered rather than patient-centered. While this alone does not mean that such activities are therapeutically good or bad, there is additional concern as to the extent to which such programs are meaningful to patients and whether they are purposeful steps toward the goal of returning home. The attitudes of individual patients toward various aspects of hospital treatment are known. The authors of *A Mind That Found Itself,*[1] *Snake Pit,*[2] *Asylum,*[3] and *The World Next Door*[4] have given us considerable insight. To what extent have we utilized this information in patient care? Are we doing things *to* and *for* patients rather than *with* patients?

This paper is a preliminary report of some of the material collected during a socio-cultural study of an outstanding psychiatric hospital. The study was undertaken to gain a better understanding of the hospital environment, particularly differences and similarities of a cultural sort, as compared with the community environment found outside the hospital. We hope the information will be helpful in establishing more effective methods of psychiatric-hospital treatment.

The project has been conducted during the past two years by the Institute for Research in Social Science of the University of North Carolina, under contract with the United States Veterans Administration.[5] All investigators have sought to view the hospitalized patient as a participant in a socio-cultural system. The corollary hypothesis that was kept in mind was that the patterns of behavior and attitudes of staff members affect patients and *vice versa.* The research team feels that its principal contributions, whatever their worth, will be in terms of social and cultural insight into the problems of patient treatment and management; the reresachers have not attempted psychologic and psychiatric interpretations.

[1] *A Mind That Found Itself,* by Clifford W. Beers. New revised edition. New York: Doubleday, 1953.

[2] *The Snake Pit,* by Mary Jane Ward. New York: Random, 1946.

[3] *Asylum,* by William B. Seabrook. New York: Harcourt, 1935.

[4] *The World Next Door,* by Fritz Peters. New York: Farrar, Strauss, 1949.

[5] The responsible research personnel have been Gordon Blackwell and John Gillin, directors of the project, and Frank M. LeBar, executive director. Lee G. Sewall has served as psychiatric consultant. The following graduate students have served as research assistants: William Amis, Joseph Borello, Roy Eck, Robert Pace, and Harold Van Cott, all of the University of North Carolina; Edwin Rubington, Yale University; and E. P. Banks, Harvard University.

Within the framework of modern psycho-cultural theory, hospitalization of any duration is actually a learning situation. This research has sought to describe and evaluate this learning process as it relates to performance requirements in outside communities. One hypothesis has been that the hospital experience does not, by and large, encourage the kind of social learning that is useful and necessary outside the hospital, and that adjustment problems following release from the hospital may contribute to relapse and necessitate a return. A necessary and final aspect of the research is to set up a controlled experiment designed to test whether the learning situation within the hospital can be altered to produce behavior better adapted to the problems of life.

At the patient level, the research has concentrated on patterned behaviors, expectations, values, and attitudes—meanings that seem to be common to patients in general or to specific groups of patients. Idiosyncratic behaviors, while interesting and important from the point of view of individual personality dynamics, are not considered to lie within the scope of this research. The research personnel have observed, talked with, and interviewed patients from the various clinical categories used by the hospital—*e.g.*, new admissions, acutely ill, chronically ill, disturbed, closed-ward, privileged, and so on. Beyond this point, no attempt has been made to sample patients systematically, for example, according to diagnostic category, age, length of illness, or any of a number of other possible criteria. Such information is provided on a special card prepared for each patient in the project. To date, observational and interview data have been collected from almost 600 patients out of a total resident population of about 1,800.

From this study we have selected a few patient attitudes of interest to us from the standpoint of the dynamic aspects of psychiatric-hospital management. No conclusions or interpretations are offered. While we are not prepared at this time to state what proportion of the patient population has such attitudes, the material, unless stated otherwise, was obtained from all groups in the hospital. The ideas expressed occur too frequently not to be of significance. Selected conversation from patient interviews is utilized to document attitudes.

It is customary for the staff to interpret the treatment program to new patients and encourage planning for an early return home. The sources of other information affecting the development of patient understanding of the hospital program is indicated in the following conversation on the admission ward:

"That E.S.T. is really a wonderful thing."

"What do you mean by E.S.T.—Eastern Standard Time?" *(All laugh at this and proceed to discuss the sensations they have experienced in taking electric shock.)*

"I know my mind ain't what it used to be, but I believe a psychiatrist could fix me up. These around here are so damn snobbish they don't take the time to sit down with you and help you work out your problems."

"No, if we had enough of them [psychiatrists] here, it would be a lot different."

"No, that wouldn't make any difference. They [the psychiatrists] just seem to act like they got more troubles than we got."

A newly admitted patient being welcomed by two "old-timers":

"They're going to give me insulin shock—send me over to 1D [acute-treatment building]."

"Don't let them put you on the bullpen over there; that place is hell."

"Aw, he won't go to the bullpen. The insulin patients stay on the first floor."

"You'll be as fat as a butter ball after awhile. They say it don't hurt you none when they give it to you."

"Well, I don't particularly want to go, but I got to. I feel like I'm going on trial."

"Well, you don't have to worry. A lot of us have taken it."

Another:

"They can transfer you over on the 70's [continued-treatment wards] and keep you until some one comes and gets you out. Over here [admission ward] they can let you out without some one coming for you."

"Yeah, when you get over on the 70's, you're a goner because you'll be a long time getting out."

It is customary to assign patients to activities ordinarily accomplished by hospital employees. Is this desirable? From a patient:

"I would like to be put to work. It keeps my mind off things and I do not have to be in such close contact with other patients."

Another conversation:

"I'm on K.P. now, so I don't get around like I used to. It keeps me busy all the time. I am glad I am on K.P. They [doctors] send a lot

of patients home from K.P. When they assign you to K.P., they are usually getting ready to send you home."

Still another:

"There's a three-day holiday coming up. That's fine for you people who work here, but it's awful for us on a long holiday. I would like to work seven days a week. I enjoy doing this. It's the only thing I can look forward to."

And again:

"No, it isn't work. Most of the patients, if they are not put on a job, they go haywire. It takes him [patient] most of the morning to sweep and mop the floors. He takes a great deal of pride keeping the floors spotless and shiny."

Another interview:

"I think a patient should be conditioned to eight-hour work schedule. He shouldn't be made to feel like a mental patient. Most patients would like something in line with what he is doing in the hospital when he leaves."

It is the custom to permit patients' visits to town for the purpose of providing community reorientation prior to discharge. Is our timing of these visits always reasonable? Patients' attitudes regarding this procedure are reflected in the following:

"On a pass a patient feels very self-conscious. He has very little money and no place to go. One way to tell them [patients] is that you seldom see men wandering around town during the day. They're working. There's no place to go and nothing to do. If you go downtown at nine in the morning, you get tired of walking through all the dime stores without buying anything. Now, if the passes were from five o'clock to midnight, you could go after supper to a dance or to a movie and enjoy yourself. I haven't been downtown but a couple of times and to me, it's worse than taking a beating."

It's generally accepted as good practice to prepare the community and family for the patient's return home. Is this always the best plan? The following conversation between two patients is interesting:

"I think the best thing for a person who has been here is for a person to move to a new place when he leaves here. Then he won't have people asking him where he has been."

"No, I don't believe that is the answer. One thing I have learned in psychotherapy is that the problem we face is living with ourself. When you move, you still have to live with yourself."

"I guess that's right, but it takes some of the pressure off when you move to a new place where no one knows you."

In another interview:

> "No, never have anything to do with the public. They expect you to act crazy and when you say anything sensible, they don't like it. It's a bad situation all around."

From still another:

> "People were always asking about how I'm getting on and they got on my nerves. I got so tired I came back to the hospital to rest where it's quiet. It's got so it don't look like I can get along outside the hospital. Guess I'm pretty bad off. All I want to do is just stay around here and maybe go out for a few days once in a while."

It's the general practice to require that the nearest relative assume custody of the patient's welfare on his release from the hospital on trial visit or parole status. Does the patient's extramural status require more individualized consideration than this?

From a patient interview:

> "There's always a guardian to sign you out. They [patient and guardian] go home and have a little family fight. She [guardian] always has a club over your head, saying, 'I'll put you back in there. If you don't do what I say, you're going back.' That isn't a good environment at all. When you have some one who has you all tied up and tells you, 'Don't think. Don't go to this show. You either do this or else.' You're going to have a fight sooner or later."

Another:

> "A lot of wives and families get used to the patient being in the hospital for several months and would rather get along without him, so when he comes home, they like to shove him back. There are some very good wives and folks, though."

And still another:

> "I think the patient and his family should have a consultation together with the doctor when he [patient] leaves the hospital so that they [patient and family] could get together. Sometimes if the patient has been out for a couple of months, he will be sitting around and she [guardian] will bring up something the doctor said. This gets him [patient] all upset."

To quote again:

> "I feel it would be more helpful and encouraging to the patient to secure his discharge at the end of a short time. This restores self-confidence and it relieves concern about still being a patient at the hospital. He [patient] will not consider himself well until discharged."

We were especially interested in the attitude of the long-term patient making a "good hospital adjustment." Does this happy phrase need to be further analyzed from the stand-

point of the ultimate welfare of the patient, the hospital, and the community?

> "I like it since I have to be here and I am proud of some of the friends I have here. He [referring to another patient] made me mad talking like that. What does he know? He has only been here three weeks."

Another conversation:

> "My family write and tell me what they are doing. The truth is I'm not interested. I have been away so long I don't care what they are doing."

Again:

> "I had no idea patients were treated so well here. Sometime patients try not to get discharged because they like it here. They don't adjust on the outside."

To conclude, this research study was undertaken to obtain insight as to the effectiveness of psychiatric-hospital treatment as a means of providing the patient assistance toward a return to community living. Our observations lead us to the tentative conclusion that hospital staffs could, if they tried, see more of their program through the patients' eyes. By way of example, here are some instances:

1. Maybe a patient deteriorates, not because of anything inside of him, but because of what we do to him—compelling him to live in a non-stimulating, repressive, and rigid environment. It takes courage and imagination for the hospital leadership to provide an environment that is stimulating, relatively non-repressive, and highly flexible. It may be worth trying.
2. Every one agrees that, for the patient, hospital treatment is a "learning" experience. Now what does a man need to learn if he is to get along in the community? He needs to learn initiative, independence, flexibility, and resourcefulness. From the above conversational samples, it is suggested that what he actually learns is conformity to routine, dependence upon others for decisions, development of fixed performance and timetable habits, and reliance on resources that others make available. It would be difficult to conjure up a more useless set of patterns for a man about to go back to the outside world.

3. Again and again, patients expressed a wistful wish for more personal attention and time. Several of the really successful research projects have depended largely on giving a patient a lot of individual time and attention. With so many patients and so small a staff, the tendency toward a mass approach is almost irresistible. Somehow we must find a way to have staff—*every one* who comes into contact with patients—spend more time with individual patients. Possibly this is the only way we will open the door of our locked wards.

4. From the conversation of patients, we get the feeling that transfer to a continued-treatment ward is construed by a patient as a life sentence. Why couldn't "alumni" of continued-treatment wards come back now and then and participate in group-therapy sessions, just to provide living proof that the continued-treatment section is not a permanent assignment? It seems to us that this would be real learning, a real change of attitudes.

5. From what patients say, they know the difference between phony time-taking work and work that is a real simulacrum of productive outside toil. Could we make our hospital-industries, occupational-therapy, and detail assignments more like honest outside work—with eight-hour schedules, for instance; some system of rewards; some opportunity for suitable patients, even stabilized psychotics, to become member employees? This would be a real bridge between the hospital and community living. Again a matter of seeing all this "work detail" through the patients' eyes.

6. Giving a patient a morning-afternoon pass, when actually an evening city pass would be more effective, seems to us a good example of letting administrative convenience triumph over therapeutic effectiveness. If the matter of pass time were viewed through the patients' eyes, the staff might find at once how much more valuable an evening pass is than a morning pass.

7. It would seem to us that we ought to explore, to a greater extent, the possibility of encouraging a patient who is leaving on trial visit to go to a neighborhood

where he is not known. Patient conversations reflect the advantage of that. Perhaps it would not work, but have we again been looking at this problem only through staff eyes?

8. It never before occurred to us that the "responsible" relative had such terrible power over a patient on pass or trial visit. Patients have said that they have been returned to the hospital without reason, but, perhaps more often than is realized, failures at community adjustment are the direct result of being "blackmailed" by the responsible relative, under threat of being returned to the hospital. In selecting the responsible relative, should we not pay more attention to that relative's own personality? We are supposed to be experts on gauging personality, yet how often do we pay much attention to this aspect of the patient's preparation for a trial visit? It would seem to us that some appraisal of the patient's relative, as a part of trial-visit procedure, is certainly in order. All will agree that a sadistic, latently hostile relative is not the best person to assume responsibility for the patient.

The goal of treatment always is to construct a bridge between the ward inside and the real world outside. If we would try more consistently to see our program, day after day, *through the eyes of the patient*, we have reason to believe that this challenging goal will be more nearly approached.

DRUG ADDICTION *

C. A. ROBERTS, M.D., C.M.

Chief, Mental Health Division, Department of National Health and Welfare, Ottawa, Canada

I SHOULD like to think that inclusion of the subject of drug addiction on this program is a recognition of its importance as one of the psychological, social, and medical problems of society. The subject of drug addiction has long been confused by very strong opinions and seldom clarified by research or objective thinking. It is with considerable hesitancy that I approach this discussion to-day. At times during the past three or four years I have felt that I knew something about the subject, but more recently I have been impressed by the absence of almost any factor regarding which there is universal agreement.

During recent years it has become increasingly clear that one must define one's terms in order to avoid misunderstanding and misinterpretation of one's remarks. For the purposes of this discussion, drug addiction is limited to addiction to those drugs which are listed in Canada and the United States under Narcotic Acts and which, from a legal point of view are apparently considered to have similar undesirable effects. For practical purposes in this country, that means that we are speaking of addiction to heroin, on the one hand, and demarol, on the other. In the illicit market heroin is the drug of choice, whereas in the professional area it appears that demarol is the most widely used narcotic.

Addiction, in the sense in which we are using the term, means that a person is given to or is using one of these drugs in a way that is considered to be detrimental to himself or to others—that is, in a way that is socially unacceptable and that may possibly interfere with his physical and emotional health. No attempt is made to separate those addicted people who are using large quantities of drugs, with resulting measurable physiological changes, from those who are using very

* Presented at the Fifth International Congress on Mental Health, Toronto, Canada, August 19, 1954.

small quantities of drugs, in whom physiological changes can be demonstrated with great difficulty, if at all, and who are frequently referred to as having the "needle habit."

During recent years there has been a concerted effort to bring about the recognition of drug addiction as a medical problem. This has also been true of many other conditions that occur in our society, such as alcoholism, veneral disease, and so on. It seem important to clarify the objectives that it is hoped will be attained by the recognition of these conditions as medical problems. It is possible that we are frequently misunderstood and make serious errors in our effort to gain support for our programs because we use such brief statements as, "Drug addiction is an illness," without further clarification. On many occasions it has been brought to my attention that the treatment of certain individuals suffering from drug addiction or alcoholism or both has not been made easier, but rather more difficult, because of such statements, as the individual is now able to say, "I am sick. It is not my fault. I am different from other people."

It is common knowledge that the drug addict gives the impression that he considers himself somehow superior to the alcoholic, and that the regular and hardened criminal feels he is certainly different from either the addict or the alcoholic. The addict does not wish to associate with alcoholics when they are confined to the same institutions, although it does appear that the same individual may, in fact, be both. It is apparent that a large number of these individuals have been alcoholics at one time and opiate addicts at another. I am sure that all of those responsible for the development of these programs need much more than the statement that "drug addiction is an illness." Surely we must mean to imply not only that drug addiction is an illness; but that treatment programs can and should be developed for this condition, and that society and the individual have a responsibility to ensure that these morbid conditions are adequately treated and prevented.

It would be interesting if some one could study in detail from all available sources the attitude of legislators and professional people toward these conditions. In Canada, during the past century, as separate facilities for the care of the mentally ill have been developed, those responsible for

the legislation governing these separate facilities must have had some conviction regarding the problem of alcoholism and, in some cases, that of drug addiction. Almost all of our mental-health legislation provides for the hospitalization and treatment of alcoholic habituees and, so far as I am aware, the only legal requirement is that the patient's condition be primarily due to or associated with the use of alcohol. This legislation, which goes back over many decades, provides for either the voluntary admission or the certification of persons in whom the use of alcohol is the predominant cause of the condition that now requires treatment.

In four provinces of Canada, provision was made for the treatment of drug addicts in the same way. This certainly implies that those responsible for the legislation had some feeling that drug addiction is, like mental illness, a condition that requires treatment and that can be cared for better in hospitals than in other places of confinement, such as jails or penitentiaries. In none of these areas, however, were really successful and fruitful programs for the treatment of either drug addiction or alcoholism developed.

Is it not possible that recognition of these conditions as an illness led to the development of medical programs that were not supported by the necessary social and community aids to treatment? One might add that only in recent years has this aspect of psychiatric treatment received real recognition, and in some areas the development of real community programs has lagged sadly.

In the past few years programs have been developed for the treatment of alcoholism, and in all of these it is obvious that medical and psychiatric treatment is only one aspect of the therapy made available to the alcoholic. This medical-psychiatric treatment is supported by programs of individual reeducation, community education, and what might be described as social therapy. In only one or two places has an attempt been made to treat drug addiction in the same way.

A few years ago it was not uncommon to hear psychiatrically trained physicians state that they could do nothing for the alcoholic; that many alcoholics did not really want to be treated; and that this problem was one for which psychiatrists would rather not assume responsibility. This attitude is now changing and many of our hospitals are quite success-

fully providing the medical part of the treatment program, in coöperation with Alcoholics Anonymous and alcoholism foundations.

Today, however, one hears that the person addicted to drugs is a most difficult individual, does not really want treatment, has never amounted to anything before becoming addicted, and cannot be satisfactorily treated except in a custodial institution with legal compulsion provided. This may or may not be true, but one wonders if it would not be highly revealing to have a treatment program, similar to those developed by the alcoholism foundations, as an experimental approach to the treatment of drug addiction.

It appears that our recognition of drug addiction as a medical and social illness could do much to overcome some of the social problems that now exist because of drug addiction. It does not seem that a successful program can be developed unless both factors are taken into account. The institutional-treatment programs developed to date are very difficult to assess, but apparently they have not produced any dramatic favorable results. These programs have usually been isolated from the community, and this may account for the apparently low rate of successful treatment. As with all problems of rehabilitation, it would seem highly desirable to organize programs that keep the individual in as close contact as possible with the local community.

This means that services must be developed at a local level, and it seems doubtful whether the organization of a centralized institutional program in the absence of local services is warranted by the present extent of drug addiction as a social-medical problem. If, however, ways can be found either to combine a centralized institutional program with local rehabilitation activities, or, alternatively, to combine local rehabilitation programs with local arrangement for institutional care when necessary, it would seem that the time has come when something should be done, particularly in those areas where drug addiction is prevalent.

It is well known that drug addiction occurs almost exclusively in those who have comparatively ready access to drugs. We, therefore, see drug addicts to a varying extent amongst certain professional groups, in patients under medical care,

and in certain members of our population who frequent areas where illegal drug supplies are available.

As far as the professional group is concerned, it would seem that improved education regarding these drugs is necessary. A most progressive step would be the recognition by professional people who are becoming addicted, or by their professional colleagues, that more acceptable resources than drugs are available to them. These professional persons have a good many resources that can be utilized in treatment, and we should encourage them to seek help when they find themselves in difficulty.

It would also seem desirable for professional persons administering drugs to patients to be much more familiar with the way in which addiction develops, and the signs of dependency, so that other methods of treatment can be applied before their patients become addicted.

The largest group of drug addicts, however, are those who obtain drugs from illicit sources and who apparently have not been introduced to these drugs through medical treatment. Many attempts have been made to classify these individuals from a psychiatric point of view, but such classifications have not been too revealing. It does appear that most persons who become addicted have certain characteristics that would allow them to be classified as of other than normal or average personality make-up. We do not know whether these people are in any way different from other psychopathic or inferior neurotic individuals who do not use drugs, or whether they are similar or different from those people in our society who are alcohol abusers. We know that many more individuals use alcohol because it is more readily available and, therefore, the classification of alcohol abusers from a psychiatric point of view would probably show some differences from those who use opiates.

More significant than the attempts to classify these people from a psychiatric point of view is a review of their personal histories prior to the age of twenty. Here we find that the family situation and educational history can be considered as variants from the normal patterns. It does seem that the development of a better mental-health program in our schools, and awareness not only of the individual's make-up, but of the social conditions under which he is living, would

enable us to redirect these children before they begin to frequent areas in which drugs are available.

It also seems that drugs are available only in selected areas of our cities and that these areas are characterized by the existence of slums, cheap boarding houses, taverns, and restaurants that are well below acceptable standards. It is in these substandard areas that most of the socially undesirable members of our society congregate. It seems probable that improvement of these districts will seriously interfere with the distribution of illicit drugs. This interference must be combined with control, as far as possible, of illicit drug supplies. This is a matter well outside the field of medicine, but it does appear that effective enforcement action can do much to reduce the size of this problem.

Periodically there is a flurry of activity by groups of individuals who feel that the proper treatment of drug addicts would be to register them and supply them with maintenance doses of drugs. It has been demonstrated that all of these drugs have certain physiological effects on the individual, and that these individuals are physiologically different when they are under the influence of drugs. It is difficult to believe that responsible groups can advocate the maintenance of an abnormal physiological state or the chemical support of individuals in an abnormal psychological condition. All drugs, when taken in certain dosages, become toxic and from a psychological and social point of view the quantity of drugs taken by an addict is toxic and harmful to society. Even though the main justification for such a program is the absence of techniques that will successfully enable us to treat all addicted persons, we must surely continue to study these conditions and to attempt treatment by more acceptable means.

In conclusion, I would like to emphasize my belief that drug addiction is a medical, psychological, and social illness. Such recognition implies that, as with all other illnesses, both the individual and the community have a responsibility for the initiation of adequate programs for treatment and prevention. There are indications that it is possible to do a great deal for the addict if medical, social, and rehabilitative methods are applied in a coördinated way. The prevention of drug addiction will require an expansion of our school mental-health programs, so that variations from acceptable

behavior can be detected and treated before the opportunity for addiction to drugs has been presented. It does not appear that the medical and social services can develop an adequate program of treatment and prevention until the community can emotionally accept its responsibilities as well as an intellectual understanding of the factors involved.

A successful program for the prevention and treatment of drug addiction will require concerted community, social action to remove from our cities those areas in which drugs are available, to provide adequate opportunity for our youth and an emotional-social atmosphere that will make possible genuine rehabilitative efforts on behalf of treated drug addicts.

VOLUNTEERS IN COMMUNITY MENTAL HEALTH WORK*

THE RESPECTIVE ROLES OF LAYMEN AND PROFESSIONALLY-TRAINED PERSONS

IRENE T. MALAMUD

Executive Director, Massachusetts Association for Mental Health, Inc., Boston

THE concept of the volunteer in a community mental health program is less clearly defined than it is in some other connections, such as in hospital work or in certain types of social agencies. There has emerged a tendency in the mental health movement to equate the concept of volunteer with citizen or lay person and talk in rather broad terms of a "citizens' movement"—a concept which contains certain basic misconceptions which contribute to the difficulty of making any clear-cut definition of what is meant by a community mental health program. Such a program is still thought by most people to be synonymous with clinical services, with their focus on the treatment of illness. When they try to think about "mental health," it becomes vague. It seems to be bound up with "happiness" and "the good life" and other desirable goals but does not seem to lend itself to practical community planning. Mental health workers have a primary responsibility to interpret to the community that a mental health program is not a vague, "fuzzy" dream of a good life, but is an integral part of present-day medical thinking, and is subject to the same principles that operate in all public health practice.

Today, medicine is no longer thought of as narrowly concerned only with the study of disease. The concept of "public health" has broadened our medical horizons by recognizing that effective health programs can never be solely the responsibility of the medical profession. The present-day approach is perhaps best defined in a report of a committee concerned with outlining a program of medical care: "Comprehensive medical care may be considered as a concept of coördinated

* Presented at the Fifth International Congress on Mental Health, Toronto, Canada, 1954.

health services directed at the continuous maintenance of the individual in an optimal capacity in society through his own efforts and those of the community. The several aspects of this concept include the education, organization and services needed for the promotion of health; the prevention and control of disease; diagnosis, cure and palliation of illness; and rehabilitation." Contained in this definition is the basic concept that a health program is based on the participation and support of many members of a community, who may make their contribution either on a paid professional basis or by a voluntary contribution of effort outside their regular social, economic, or professional rôle. It is in this latter sense that a more proper definition of the concept of the "volunteer" might be set up . . . that the volunteer in community mental health is anyone who contributes services outside his regular job and without payment for these services beyond occasional expenses. Thus, the volunteer may be a lay person, a professional person outside the field of psychiatry, or a professional worker with specific training in any of the various psychiatric disciplines.

As a member of the community, the citizen has a rôle of vital importance. In the last analysis, a mental health program, just as any health program, is a community responsibility. In order to meet this responsibility, there must be greatly expanded research programs into the nature and causes of mental illness, so that more effective and rational methods of treatment may be developed. As knowledge about the causes of illness increases, we will be able to develop preventive programs which will be truly effective. The present facilities for training must be greatly increased so that there will be sufficient personnel to carry on these tremendous tasks. This cannot be accomplished without an informed public who sees to it that these measures are carried out.

The citizen has other responsibilities, too, as an individual living in a community. He must become informed accurately and adequately about what the mental health profession can tell him regarding mental illness, regarding treatment and preventive facilities, and about the many problems in rehabilitation. Beyond that, he must find out about those mental health principles which he himself can and must carry out if the level of mental health is to be raised. This is a familiar

situation in such things as nutrition, for instance. We know that there are pathological conditions in which dietary regimes must be under the direction of the medical expert. However, in the broad fields of nutrition the basic principles of a balanced diet must be carried out in the home if our children are to have a good physical start. The same is true of mental health. The foundations for good mental health are laid in early childhood and are dependent on the degree to which parents, teachers, and others know and apply available knowledge about personality growth and development. The principal rôle of the citizen as an individual is to realize the part he himself must play in assuring better mental health for himself and his family. He may then join with others to form a local Mental Health Association or Committee to assume responsibility for some aspects of a community program.

The Massachusetts Association for Mental Health has, for the past three years, been carrying on a program with these (citizen) volunteers in the local communities to help them find ways of meeting the many problems that confront them at the community level. In October, 1951, a one-day Institute was held, to which were invited representatives from the Mental Health and Public Health fields and interested citizens in local communities. The day's activities began with three brief keynote speeches by three Public Health physicians, two of whom were psychiatrists. The participants then broke up into small discussion groups under trained discussion leaders and spent the day sharing their problems and experiences, and trying to arrive at some clarification as to how best to establish mental health programs at the community level. During the rest of the year, the Community Consultant, who is a member of the staff of our Association, maintained direct contact with these communities that had set about the task of getting the program going. He served on a consultant basis and gave whatever kind of assistance was requested. The following year a continuing Workshop was set up, which met every two weeks for a number of months, in which these community representatives had the opportunity to share their problems with each other. From time to time a more formal presentation was given at these meetings by some outstanding worker in the mental health or public health fields.

This spring, another one-day Institute was held along much

the same lines as the first one, except that it was primarily set up for those who had been participating in this project over the past three years. The theme of the Institute was the "What, How, and Who" of Community Mental Health and three discussion groups were set up around these three areas. Instead of speakers, the day's program was keynoted by a panel of representatives from four communities that had already established Mental Health Committees and had become active at the local level. This whole project is under the supervision of a Committee whose chairman is a member of our Board of Directors but which is mainly composed of members who represent the local communities or are from the public health field.

A rather different kind of project has developed as we have realized the necessity and importance of reinforcing our small staff with others who can play a vital rôle in an effective program of preventive mental health and of mental health education. There are many people who, by virtue of their particular skills and their particular function in the community, provide the resources without which a mental health program could never be carried on. This is true not only because there will never be a sufficient number of adequately trained mental health personnel to do the job, but also because there are some areas in which they cannot do certain jobs as effectively as the volunteer.

One such program developed by the Association is the "School Project" where for the past six years a training program for teachers, guidance personnel, and others in the field of education, has been carried on. This project consists of courses in Mental Hygiene Principles and seminars in Group Dynamics under the leadership of analytically trained psychiatrists. Workshops for school personnel were introduced, staffed by members of the Association's professional staff, representatives from the State Department of Education, and from the State Department of Mental Health. All of these are set up on a semester basis and teachers receive in-service training credit, required for salary increment. Academic credit is also given for the courses and workshops, and it is hoped that this will be available for the seminars before long.

Originally the goals of this project were to bring added knowledge and skills to the participants in the handling of

their own professional responsibilities. However, this year, with the demand for workshops increasing, a selected group of those people in the field of education who have had our various training projects have been drawn in to serve on a volunteer basis as "faculty" for some of these workshops. A demonstration program has just been completed where four out of a staff of five were people from the educational field. A special seminar in supervision for this group was set up under the direction of Dr. Kenneth Benne, Director of the new Human Relations Center at Boston University. It was found that this group of educators, with their special orientation in the mental health approach, did an exceptionally effective job with teachers because of their ability to identify with the teachers' needs and attitudes in a way that outsiders were never able to do. This selected group will be expanded and will thus provide an important additional group of mental health personnel who are making a special contribution to the community program on a voluntary basis.

A different type of training program being carried on this year has certain definite implications for volunteer activity, although on a somewhat different and more indirect basis. A member of our staff conducted a twenty-week program of mental health education with the staff of a local Health Department. Through the presentation of some didactic material but mainly through group discussions, the entire staff of the Health Department, which does not include any specifically qualified mental health person, was enabled to incorporate mental health principles and a mental health point of view in doing their own particular jobs. Because of this orientation and the interest developed in this approach some of these people are now serving in a volunteer capacity on a newly organized Mental Health Committee in their community, and are giving guidance and leadership in a very special way.

Community Education.—Perhaps the widest use of volunteers at the community level is in the "Community Education" program, which is the term used to designate the work with the many groups who ask for a program on mental health for one or more of their meetings. When the Association reorganized its program about six years ago, one of the things which came in for some critical appraisal was the so-called "Speakers Bureau," which consisted of a long list of outstand-

ing people in the field of psychiatry who had indicated their willingness to "give lectures," but who were being called upon very rarely because it was found that requests for talks were not very frequent. After considerable thought, it was decided to try an entirely new approach. When groups did call in asking for programs they were asked whether they would be willing to consider something different from the traditional lecture. The new field of "Group Dynamics" had made its appearance in this area and many people were experimenting with the various techniques of group participation and group discussion, and finding an enthusiastic response. A few films were available and it was felt that by using these as a "jumping-off-place" for discussion under skilled leadership, interest in mental hygiene principles might be revived at a different level. In the beginning, it took some time to find organizations which were courageous enough to try something new, but after a few of them had this type of program the response was so favorable that word-of-mouth communication took care of any problems of demand. From approximately forty requests during the first six months of this new type of program, the number almost doubled for each of the next three years and has now leveled off at nearly five hundred requests for each of the last two years.

By this time our film library has grown considerably and we have found other audio-visual aids, such as the American Theatre Wing playlets, film strips, recordings, and sociograms, to be very helpful.

The success of this whole program, however, depended primarily on having available a group of competent discussion leaders. At first the staff could handle the requests, but it soon became obvious that we would have to add others from outside sources. Boston is fortunate in being a center which attracts numbers of young psychiatrists who come for their residency training, which includes training in working with groups at the therapeutic level. The directors of some of these psychiatric training centers felt that experience in the community, working with "normal groups," would be a valuable additional experience for their residents. Information about the Association's program was given by these interested directors, and the residents were encouraged to participate. We think it has been important that at no time have we tried

to recruit these leaders. They have called voluntarily and asked to become involved. As time went on a few clinical psychologists and psychiatric social workers from other agencies have been added.

An effort is made to have a personal interview with each new applicant to interpret the goals of the program. It is made clear that in most cases there is no fee, although occasionally a group will pay a small honorarium to cover expenses. In general, it is presented to the prospective participants as an opportunity for a new learning experience in which their rôle is not that of the "expert" giving out the last word in wisdom, or doing therapy in the usual sense of group therapy, but rather that we are experimenting with a new type of relationship the exact nature of which is not yet clearly defined. This preliminary interview is a time-saver, since occasionally an applicant will decide that he is not interested in the program; but usually it is seen as an exciting and challenging opportunity. Regular monthly meetings are held with this group, on a seminar basis, in which they are encouraged to talk out the problems that they meet in the community groups, as well as their own feelings about them.

This seminar has developed into a very important part of the program. It is a difficult job for these young psychiatrists to adapt their skills and their clinical attitude toward personality, which have become primarily oriented toward sick people, in such a way that they can be used effectively with normal groups concerned about normal problems. Each year as new psychiatrists come in the argument goes on as to "there is no such thing as a normal person," "whenever we meet with such a group we are doing therapy." It is often found that the first few meetings conducted by new leaders prove somewhat frustrating, both to the leader and to the group. Over-permissiveness and an exaggerated "non-directive" rôle is not easily accepted by groups who are accustomed to much more structured programs, and the task is one of achieving a "middle-of-the-road" pattern which permits and encourages participation and free discussion of feelings, but which offers enough control and structure to keep the discussion from being too anxiety-producing and threatening. In time, leaders begin to see these meetings as a real sharing

between themselves and the participants, each having a special contribution to make, each having a special body of knowledge from which to draw.

The "single" meeting is, of course, the most difficult to handle on this basis and requires particular care in trying to interpret just what can be considered as legitimate and constructive goals in such a situation. In the seminar, it is emphasized that such meetings are useful primarily to offer a taste of a new kind of experience in which, just as in therapy or casework, the establishment of a relationship is the primary goal. Groups are encouraged to pursue this type of experience by setting up a series of meetings, in which case some real progress can be made in helping them gain insight into some of their feelings about their interpersonal relationships. In the training program of these leaders, there is always a phase of frustration and disillusionment, usually at the beginning of the year, when the psychiatrist, who is accustomed to sitting in the seat of authority in his clinic or hospital, finds himself competing with a business meeting, melting ice cream, or a trumpet solo by the top musician in the eighth grade. His whole perspective must change as he tries to define what his rôle in this kind of situation actually is.

One of the drawbacks in such a program is the fact that as yet there is not a valid way of determining just what results are obtained. The increasing number of series of meetings is one indication that a need is being met, but even there we have not been able to measure just what is really achieved. Satisfactions are still mainly subjective and are best expressed perhaps in a typical comment from a leader, "I came away with a good feeling—I don't know why, but things seemed to click and I had a feeling the group got a lot out of the discussion."

We have consistently maintained that these meetings should be carried on only with psychiatrically-trained professional leaders. The main value of this kind of program lies in providing an opportunity for a direct "feeling experience" in which some anxiety is allowed to be expressed and in which hostilities are quite obviously coming out. There needs to be skillful understanding of the extent to which feelings may be permitted to be expressed, and a knowledge of how to control

and alleviate these group feelings. Lay leaders may be very effective in discussion groups where participation is much more on an intellectual level and these certainly have an important place in our social life today. However, a mental health education program should go beyond this and begin to move toward participation at the feeling level. This should be one of the unique functions of a mental health program and since this is the province of trained mental health personnel, such as psychiatrists, psychiatric social workers and nurses, it seems to us to be necessary to keep it in their hands, trying to provide them the opportunity to adapt their basic skills to this kind of work which is not primarily geared to pathology.

In summary, then, the Massachusetts Association for Mental Health feels that the "volunteer" is an indispensable part of its work in community mental health. On the one hand, volunteers augment the always numerically inadequate corps of employed mental health workers, and on the other hand they carry out certain tasks for which they are better suited and more strategically placed than mental health personnel ever could be.

The volunteer may be a lay person who becomes informed about the principles of mental health which he applies in his everyday interpersonal relationships, thus contributing to a firm foundation of mental health in himself, his family and his community. At the community level, he may also join with others on an organized basis to develop and support those agencies who carry on sound mental health practice.

The volunteer may be a professional person outside the mental health field, who, because of his special function as a key person in the lives of people, becomes integrated into a community mental health program as an ally who can make a vital contribution. The work with teachers and with the health department personnel are examples of the special contribution of this type of volunteer.

Finally, professionally trained psychiatrists and others in that field have another kind of contribution to make as they adapt the skills and knowledge of psychiatry to helping community people understand their normal problems a little better

and help them resolve some of these problems in a more constructive way.

Inherent in all of these activities is the unique and inestimable value that lies in the fact that they are voluntary—in other words, that they are contributions of time, interest, and knowledge on the part of many kinds of people to help get on with the job of making our communities better places in which to live.

THE SOCIAL SCIENTIST'S CONTRIBUTION TO GOVERNMENT*

HERBERT L. POTTLE, PH.D.

Minister of Public Welfare, Newfoundland

THE straightforward article of belief underlying this paper is that man is fundamentally the same wherever you find him. If, therefore, we gain valid insights about him anywhere, these ought to be available for the good of mankind everywhere. There are those who believe that what is now happening to people in Newfoundland, a small definable cultural entity in the Western world, should be significant for all disciplines which are dedicated to the study of man.

In particular, this paper will describe some of the fundamental social and economic changes that have taken place in Newfoundland recently and are still in progress, the responsibility which government is taking in initiating and directing these developments, and the special rôle within the total framework of government policy which social science is trying to fulfill within the broad field of the social services, with its focus in public welfare.

There are some special features which should make the Newfoundland scene unusually fascinating for the student of human affairs. In the first place, the transformations have appeared practically overnight. What in the ordinary course of events would require a period of many generations to develop has happened before our eyes in a mere fraction of one generation. In the second place, this basic betterment in social and economic conditions has come upon a people whose traditional standard of living has always been below that of most parts of the North American continent. Furthermore, the Newfoundland culture has been highly stable and homogeneous over the centuries; consequently sudden and pervasive social changes can be the more readily observed and their effects the more easily traced.

* An address given to The Fifth International Congress on Mental Health, Toronto, Canada, August 18, 1954.

Background.—What Ebbinghaus said of psychology can be as truly said of Newfoundland—it has had a long past but a brief history. As far as North American settlements are concerned, the Newfoundland settlement is the grandsire of them all. But because of a colonialism whose mercantile philosophy regarded Newfoundland as a mere fishing station moored in the Atlantic, permanent and legal settlement in the island was delayed until a century-and-a-quarter ago. All the while our cousins here on the continental mainland were organizing themselves into communities, raising their families, choosing their governments, we Newfoundlanders were battling for the primitive right to settle at all; outlaws, in fact, on alien soil. It is this lag which accounts in part, but only in part, for the urgency and tempo with which events are at present moving in Newfoundland. There is so much lost time to regain and it is later than we like to think.

Up until fifteen or twenty years ago the typical Newfoundland settlement was a well-knit community of a few dozen homes fringing the coast line and the fishing grounds. Around the cod-fishing industry in summer, the entire family were mobilized—the men, the womenfolk, and the children. In the other seasons, the head of the household supplemented his earnings by logging, sealing, carpentry, and sundry such occupations. There was always the small vegetable garden to bolster the family diet. Where the same church bell summoned the entire community to a common altar, and where a single shout for help called all hands to the beach, there the ties of what our greatest poet has called our "uncontractual blood, without terms and without drill commands" welded community into communion. Even the larger industrial and quasi-industrial centres had not outgrown themselves, and neighborliness and intimate personal relations up and down the street were the characteristics of our common life.

Until the turn of the present century, ours was a one-industry economy: fishing. We were remote from markets; we were extremely vulnerable to the slings and arrows of economic uncertainty; and our politics were notoriously insular.

The hard economic fact was that we could not stand alone. And finally in the wake of a succession of reverses the waves of the great depression quite vanquished us. In 1934, by which time the cost of servicing our public debt had become

60 per cent of our current revenue, an unprecedented event in the annals of English-speaking peoples happened to us: we lost our self-government, and from 1934 until we became a province of Canada in 1949 our administration was a caretaker government, a six-man Commission, appointed, not elected. What our actual constitutional status was during those years is uncertain. Some wag described us as a Dominion on leave of absence.

It was, however, the era of Government by Commission that saw the turning point in our current history. For the years of Commission spanned the years of the Second World War when Newfoundland awoke to find herself famous in a new rôle. The ancient colony, which for centuries was spoken of as a nursery for seamen, had now become a front-line garrisoned fortress for hemispheric defense. Our city cobble streets and outport dirt roads echoed to the military tramp, tramp of what we not unkindly called "the invasion." And the boom of defense construction lured the fishermen-carpenters away from the fishing boats in search of the new-found dollars.

Our isolation, never splendid, was breached. We were flattered by the attentions of the outside world. We were dazzled by the uniforms. The younger generation was moving away from the kerosene lamps to the bright lights. The traditional community was breaking up. The staid old city of St. John's was bursting its seams. Newfoundland was taking on a new look, and, although there were some ugly patches, the total prospect was hopeful, in fact prosperous. Indeed the government of the day had amassed a record surplus.

The war and the aftermath of war had, furthermore, increased a demand for our exports, not only fish, but, by this time, our minerals and our paper. The public euphoria created by the treasury surplus brought our people politically back to life, and the old political cry of "time for a change" began to be heard in the land.

Union with Canada.—Newfoundland was then thrust into the throes of an internal struggle, in which the issue of return to former independent status was pitted against that of union with Canada. Following two referenda, during which the deepest passions of the people were evoked, the country split

almost evenly in two, and the decision to join Canada was carried by 52 per cent—a bare majority.

It can be stated as a fact that this economic buoyancy, this social upheaval, was caught up in full and gathered amazing momentum when Newfoundland became a province of Canada. Union did not originate all the developments I shall now summarily describe but it did set many of the most significant ones in motion and accelerated many others that were on the way.

On the economic side, Newfoundlanders generally, within the last few years, began to enjoy a standard of living far beyond anything they had ever experienced. In the atmosphere of confidence and hope created by union, the provincial public services were extended in every direction. The Newfoundland government undertook a vast program of economic expansion and, besides strengthening the basic industries, introduced about twenty new ones, financed partly or in whole by public funds. Civil servants' salaries were raised considerably. Since union, the vote for education was stepped up by 75 per cent, the votes for public health and public welfare by 104 per cent. Newfoundland has taken fuller advantage of the National Housing Act proportionately than any other province of Canada. And the rate of our population increase is perhaps the highest in North America.

Moreover, upon union, numerous federal services were introduced into the province, further modernizing and extending our public utilities. Salaries of C.N.R. employees were increased, and our entire transportation system was basically overhauled.

Furthermore, as a province of Canada, Newfoundland at once became entitled to a staggering variety of welfare benefits: family allowances, considerably improved old age pensions, unemployment insurance, increased veterans' pensions, and pensions to the blind. The social transformation that has rejuvenated Newfoundland within the last few years shows itself at its best in the faces and indeed in the whole deportment and *joie de vivre* of its children. For family allowances alone were, in my view, the greatest single social event that has ever happened to Newfoundland. A close second is the old age pension. These two social measures taken together symbolize the dawn of ampler life for Newfoundland. Their significance for the solidarity of our family life is beyond

calculation. For whereas prosperity thus far had taken care of the wage earner in the middle-age brackets, family allowances and old age security have given new status to the dependent members of the family, and the total impact of these measures is a result that cannot be estimated in monetary terms. We must add to the effect of these federal benefits the fact that the Newfoundland government was fast putting its own welfare house in order: it had upon union created a separate ministry of Public Welfare, and within a year or two of union had legislated for a rounded system of security comparable in scope, if not in scale of benefits, to any of the other provinces. Thus the sudden flood of dollars upon Newfoundland was spread more evenly over the entire province. As a result, the great bulk of our people who normally had seen little or no live cash from November to June now found their pockets replenished regularly with spending money every month of the year. Altogether the luxuriant largesse of the welfare state was making itself felt in Newfoundland in spreading and impressive proportions.

The buoyant effect of this increased prosperity has just been shown up in a recent statistical survey of purchasing power covering the year 1953 for Canada and the United States. The figures show that whereas the retail sales volume for all Canada increased by 4.6 per cent over the previous year, the increase for Newfoundland was 38.9 per cent. That is to say, the acceleration of private purchasing power for Newfoundland was far greater than for Canada as a whole.

On the more specifically social side, the changes wrought upon our people within the past few years have been equally stirring. Local municipal government has continued to extend itself, giving the smaller communities what the social workers love to call the experience of "participation." New roads have brought a sense of togetherness all over the province. Town planning has become a lively topic of concern and practical action. Regional libraries, the national network of radio, the long-distance telephone, the services of the National Film Board, and air travel are all multiplying our contacts with the outside world and with one another.

In the light of these urgent and challenging circumstances, I shall now indicate how Newfoundland public welfare is defining its responsibilities and is attempting to discharge

them as a public service. In the first place, I shall relate public welfare policy and program to total government policy and program. Second, I shall describe how we are trying to articulate what we believe is a sound welfare point of view both among ourselves as welfare personnel and to the public generally.

Public Welfare and Government.—The new government, following union with Canada, was confronted with great expectations from the public. Now with their political affairs in their own hands after fifteen years of political holiday, their elected government, especially being the one that had advocated union, had to "deliver the goods." The government responded on a double front: economic development and a vast extension of the social services.

From the very beginning we of the social services considered it our proper mission to help establish and preserve harmony and balance between these two poles of government policy. The more that economic development stressed the importance of our natural resources, the more we felt it necessary to draw attention to our human resources. When full employment and improved material benefits were idealized, we considered it our responsibility to accent our permanent human values, what the poet calls our "master passion, of giving shelter and of sharing bread." And alongside of government intervention we have placed self-help and joint effort as the essential partners.

Public welfare in Newfoundland has taken some responsibility among those departments of the cabinet representing the social field, in regarding the social services as a totality rather than as discrete, departmentalized activities. In this way, public welfare often has its best work done outside its own departmental limits—sometimes by Education or by Municipal Affairs, by Public Works or by Health. Not least of all is Welfare being supplemented and reinforced by Health. It was not always so in Newfoundland. Indeed, although joined together on departmental letterheads they were unequally yoked in the field and even pulled in different directions.

It is our belief that this wholeness of approach within the related areas of social service not only makes for more effec-

tive government administration all round, but it is also more easily understood by the people.

We have felt it our business, moreover, to have it established as a part of total government policy, and to demonstrate in the open, that public welfare is at best a positive and preventive enterprise. This point of view is new to us in Newfoundland, and, in fact, runs counter to our traditional social philosophy. For there has been a prevailing tendency for the more fortunate among us to look upon the condition of the less fortunate as mainly their own fault: if they strove harder they would not be in such a predicament. Public welfare in former times reflected this outlook by casting itself in a negative mould, consisting mostly of relief, and the only agent of public welfare at large was the relieving officer. His duty, as his title suggests, was to give assistance, "the dole," as a last resort and even then only the barest minimum. Sometimes the relieving officer drew official wrath upon himself by allowing his humanity to get the better of him. But at best it was a negative system—characteristically too little and too late.

We believe we have it now ensured as an essential feature of government policy that public welfare must become, just as public health has become, positive and reconstructive, not a stop-gap; that it must be preventive, as mothers' allowances in fact are preventive, and not a palliative; that public welfare dollars wisely administered are an investment in human life.

Public Welfare Personnel.—I come now to consider how these views on public welfare become translated, so to speak, into action, and for this purpose I turn to the question of welfare personnel.

Immediately upon union with Canada, Newfoundland marked the significance of that event for the social services by setting up, as I have said, a separate ministry of Public Welfare. The new department began at once first, to select permanent staff; second, to give them as much training as possible as speedily as possible, bearing in mind the suddenly increased responsibilities of welfare on the one hand and the urgency of the situation on the other; and third, to decentralize the central authority throughout the province into local welfare units.

The social workers selected were those who had had experience in various related professions, such as teaching and nursing or in some organized community activities. They were, without exception, non-political appointees, interviewed by a departmental board and appointed by the government as civil servants. In Newfoundland, it should be said, the government carries by far the major load of welfare services; the municipalities, for instance, which are created and fostered by the province, undertake no welfare responsibilities. Inasmuch, therefore, as such great weight of power rests with the central government, we have resisted, I believe, the temptation to abuse that power by being particularly careful in the selection of and instructions to our personnel.

In the training of our field staff, we were faced with the alternative of giving them either the full professional course, which would necessarily have to be spread over a long period, or of giving them a special shorter course of in-service training with a core of basic welfare and adapted to the Newfoundland scene. We chose the latter. The University of Toronto School of Social Work has conducted two successive summer schools exclusively for our welfare personnel; the first in Toronto, the second in St. John's. Our supervisors, some of whom have already had professional training in social work, are getting further special training at Toronto in the same way, the field work being provided by and under the direction of the Department of Public Welfare of Toronto. While in training, our staff in the majority of cases, have been maintained by the government, with full salaries, while on their part the staff forfeited their annual leave and, in some instances, paid a proportion of the maintenance costs. At this moment, a team of two welfare consultants from Toronto are in the field in Newfoundland meeting groups of our regional welfare officers in five different centers over a period of six weeks.

Bearing in mind our relatively simple community life, which is rich in human relations, we have attempted to personalize every aspect of our training of welfare officers. Summarily this means that we regard training principally not as technical competence in specific skills but rather as the cultivation of certain human beings to help reconstruct and render more meaningful the lives of other human beings. Skills, we hold,

are not an end in themselves, and we maintain as consistently as we can that forms and techniques are our slaves, not vice versa.

Pursuing this personal emphasis in a number of directions we endeavor to keep open the avenues of communication between headquarters and staff all along the line. For the mental and moral health of the whole departmental organism we encourage mature criticism of official policy from the field, so that such end results as legislation and administrative procedures come to represent by and large the general consensus and not a minority decision handed down from on high. In the absence of sufficient supervision, to date our field staff members are expected to visit headquarters and discuss their personal and official problems with divisional heads.

Moreover, the training sessions to which I have referred and others which we organize on our own are attended not only by the welfare officers but also by the senior staff of the department. These meetings of give-and-take among personnel of various levels of responsibility are indispensable, we find, for the smooth and happy operation of a spreading public service which is linked so closely to the lives of all our people and especially our very dependent people.

The personal factor is still further recognized in the placement of welfare officers. As far as circumstances will allow, each regional worker is "matched," so to speak, with his appointed district on the basis of all the reliable and relevant information available concerning both the worker and the district. Every reasonable step is taken with respect to such matters as housing, location in the district, and education of his children, to ensure that the worker will be happily placed in his regional centre.

Since 1949, when the Department of Public Welfare was first created, 49 such regional centers have been set up, each staffed by one, two, or three welfare officers, depending upon the size of the area and the density of population. The relieving officer has thus been replaced everywhere by the welfare officer, who administers the entire range of public welfare services. He is, for all practical purposes, the department in the local area, and, in fact, carries out many duties from time to time on behalf of government in the community which are only indirectly related to public welfare proper. For

instance, last autumn, when the government felt that the fishermen should be paid an extra $1.50 per cwt. for their fish, and no way could be found of getting this money into their hands promptly all over the province before winter set in, the welfare officer's services were enlisted. He collected the fish receipts from the fishermen and paid them by check on the spot, probably three-quarters of a million dollars in all. (It is an interesting sidelight that of all the thousands of transactions not a single claim was disputed). In such an unusual way, the welfare officer becomes caught up in the total welfare of the community and, in the incidental contacts which this kind of work involves, he is able to do invaluable interpreting of his functions as a welfare officer.

Welfare and the Community.—In addition to those duties which are tied more or less to government operations, the regional worker finds himself, something like the Hebrew prophet of old, involved in the daily predicaments of his people. Moreover, he identifies himself with them as he finds them and gives leadership where he can do most good—*e.g.,* in service clubs, in campaigns for better movies, on regional library boards, conducting boys and girls camps, etc. Thus he becomes less and less regarded as a civil servant and more and more, as Mannheim would say, a social servant. Indeed it has already developed that of all the public officials in the field, with the possible exception of the cottage hospital doctor, the welfare worker is the most closely linked with the daily concerns of the people.

It is this personal involvement with community which we in Newfoundland regard as the front-line concern of public welfare. We are convinced that the essence of good public welfare is more than efficient administration; it is more than skilled personnel; it is more than a spate of allowances, for these at best may be a system of impersonal charity, and at worst may be in the phrase of Cromwell, "a tortuous and ungodly jumble." A department of welfare, it seems to me, has two principal jobs to do: First, to administer allowances and related services—this is by far the easier of the two. The second is to identify public welfare with the total community in such a way as to help maintain the morale of the community at its highest possible pitch.

This second and higher function for public welfare is criti-

cal for Newfoundland, because there, as I have already indicated, the community is undergoing—if I may say so—a profound "sea-change." It is a change which is compounded largely of confusion, particularly for those members of the community who have not been able to find a stable status under the new conditions. Our mental hospital at St. John's, for instance, is now admitting many patients in their early forties whose illness does not fit the standard textbook patterns. They have no organic trouble, but they have lost the will to live; their symptoms are most vague, and they have little or no insight into their condition. They are, for the greater part, the less capable members of the old-time fishing settlements, which have become practically deserted. They have been left behind on the beach, so to speak, while the more aggressive ones have taken advantage of the high tide and moved out. Theirs is a kind of vocational illness. They symbolize the disorganizing effects of some of the changes that are coming upon the typical community in Newfoundland.

We may expect this psychological upheaval to increase rather than diminish. For the present government, seeking a permanent cure to the malignant disease which has plagued our fisheries all down our history, has this year embarked upon a vast scheme of fisheries-development along modern lines, such as quick-freezing and central-curing. The scheme envisages, among other things, widespread movements of population from sparsely-settled areas to a single strategic center which will have modern conveniences and the benefits of town-planning. The fabulous developments now taking place in Newfoundland-Labrador and others bound to follow shortly have implications for social change which are just now beyond our imaginings. The sense of dislocation—in some cases shock—that all this will cause to the communities involved, we expect will be considerable. The stake of public welfare in an event of this kind is likewise considerable, and we are making our plans and deploying our personnel to take these changing circumstances into account.

For these and many other such reasons the social worker in Newfoundland has a pivotal rôle to play in building up and preserving the integrity of community life, by grafting himself into the community as completely as possible, and by a constant interpretation to simplify and thus bring more

under control those forces which otherwise would create a confusing and frustrating chaos.

Even the forces which welfare itself has created could add to that chaos, if we were not on the alert day and night. And even 24-hour duty is no guarantee against the dangers I foresee, dangers around which we cannot ethically detour. For the social scientist, unlike, I suppose, the atomic scientist, has an obligation not only to draw attention to the dangers of the good he bestows but also to give leads as to how this good can be most effectively realized.

In Newfoundland, as I have already shown, we have had such an impact of social welfare benefits on such a prodigious scale and with such suddenness as altogether, I expect, is without parallel anywhere. Thus whatever hazards go along with the welfare state are present with us in full measure and of full stature. Indeed, part of the crisis we are undergoing now revolves around such questions as these: What will be the final effect of the enlarged welfare services? Will they undermine what initiative we have left, or will they undergird our common life and give us hope where otherwise there could only be despair? Will the individual citizen be lost, as one writer says has already happened, "in a jungle of benefits, doles, subsidies and pensions from which he can do no other than grab what he can"?[1] I know these questions are giving Canadian welfare in general grave concern. In Newfoundland we ask them, realizing that the battle is not by any means won. We know that the outcome will depend upon the human resources we can throw into the arena. And our public welfare is out to strengthen these resources in every possible way, both on our own and by aligning ourselves with every other agency of like mind.

Mobilizing the Human Resources.—There are numerous ways in which the social scientist will mobilize what I have called "the human resources," and I shall now broadly sketch how this mobilization can be put into effect.

For instance, inasmuch as government bulks so largely in matters of modern welfare, the ordinary individual will have to be helped toward understanding why government has

[1] See *The State the Enemy* by Sir Ernest John Pickstore Benn. British Book Centre. 1953, p. 13.

entered so deeply into private human affairs. Academically we know that this spread and insinuation of government power is "no conspiracy, no sinister plot. It is the verdict of history."[1] At the level of the ordinary day's work proper interpretation will help the common man to see government assistance as a supplement to, not as a substitute for, his own efforts.

In the modern world, as we have seen, the ordinary man's notions and convictions about his government are very important, and public welfare is rendering a vital democratic mission when it dramatizes citizens and government as partners. The much easier job of welfare, as I have said, is to distribute dollars, especially when you have the dollars, or their equivalent. But it is not so easy to make these dollars create human values, sustain them, enhance them. It is not so easy—but this is the genius of sound public welfare—to make those dollars and all their correlates build up a personal and organic relationship between people and government, so that people come to look upon the government as their government, as themselves acting together, doing the things they cannot do for themselves or by themselves—government as power made personal.

I think that the contribution which the social scientist brings to public affairs lies largely in his estimate of man and society. The dignity and the uniqueness of individuals is his first article of faith, and the second is like unto it, namely, that man and his society are interdependent. This interdependence is not merely a matter of things, but of thoughts. In the good society, power is no more relevant than compassion; it is just as relevant to raise the wretched as to rise. In the good society, there is always ample recognition not only of those who are "made of sterner stuff" but also "of the maimed, of the halt, and the blind in the rain and the cold."

The view of the social scientist, in contrast to that of local politics, is, as a rule, long-term and takes into consideration the totality of experience affecting the decisions he has to make. In Newfoundland, for instance, in setting up our various scales of allowances we have kept in mind the normal

[1] See *From Wealth to Welfare* by Harry R. Girvetz. Calif.: Stanford Univ. Press, 1950, p. 199.

earnings of the people in the same area. Thus we seek to preserve the integrity of the community in some of its economic aspects. It is our way of saying that welfare services should properly have regard for the whole cultural context to which they apply: social attitudes, economic standards, and the like. Welfare is always public welfare.

I believe we have now arrived at the point in this discussion where I can usefully enlarge upon what earlier I called the positive emphasis of social welfare. Too often our thoughts about social security, for example, have been negative rather than positive. We have stressed the security aspect rather than the social. We seem to be saying: "We had better provide security or else . . ." instead of "Being the kind of people we are, we can do no other." Too often our public policy in the matter seems to be motivated by fear rather than by hope. We lead from weakness rather than from strength.

I well recall our experience in Newfoundland in 1949 when the news of the $40-a-month old-age pension first broke upon our aged people. So accustomed had they been to the specter of fear, especially the fear of old age, that the thought of receiving $40 a month for the rest of their lives was more than they could believe. Indeed, many did not believe it and for a long time refused to apply for fear their property would be subject to seizure by the government. Others applied, but later repented, and returned the checks. Like the Happy Warrior, "born to walk in company with pain," they seemed to prefer pain as a companion to the bitter end. Security was certainly not social for them.

The effects of the old-age pension, as I said earlier, have now begun to show up positively in every part of the province. Last summer, as I went through one of our settlements where those attitudes of fear had been so pronounced in 1949, a veteran fisherman in his seventies recalled with deep feeling the transformation that had come upon his community as a result of the welfare measures, and then said to me with an eloquent tear in his eye: "Sir, there is more to social security than dollars and cents."

The social scientist in these public affairs lifts up the insight of my aged friend to the level of a social philosophy which moves our society to see social security as not just protection, but as the social conscience at work; not as a

safeguard from what we might otherwise become, but as the responsible voluntary expression of what we are.

Putting it more directly, I would say that the social scientist in public affairs, whatever his technique, whatever his verbiage, places first—and always first—the very concern which has made this International Congress possible, namely, a concern for the state of man not only for what he is, but for what he may become.

At the level of immediate experience, the social scientist desires that in the welter of this complex workaday world individual people will not be lost nor sense themselves as being lost. And he bends all his efforts toward that end. He desires that the individual will not be suffocated by the crowd; that the individual will rather gather strength from the larger unities. The ideal man which the social scientist helps to develop is Emerson's man "who in the midst of the crowd keeps with perfect sweetness the independence of solitude." Such a man will not be over-impressed with government nor with the power which accrues to government. He will refuse to be enslaved to government, for he realizes that slavery is none the less deadly because it is the beneficence of a paternalistic government that does the enslaving. He will therefore strive to remain an individual who will count. Such an individual who continually strives, him we can save, says Goethe, in that famous couplet which has an even sublimer subject for its inspiration:

"Wer immer strebend sich bemüht,
Den können wir erlösen."

The social scientist is well aware that beyond immediate experience man is pulled hither and yon by the strains and stresses of his enveloping culture. May I venture to suggest that mental illness is causing us such concern in our western society because our western society has not settled definitely on what kind of life is livable for man. A schizophrenic condition seems to mark our way of life on this American continent, at any rate. We profess a faith in the spirit of man, but we bet our lives on *matériel.* Individually we assent to the Christian proposition that life is more than meat. But collectively our taste goes to meat. The acquisitive society becomes a sick society, and we come to fear our own power.

For my part, I feel therefore that there is still something quite relevant for modern folk in that closing scene of Plato's *Phaedrus,* where "Socrates and Phaedrus, after discussing many things, turn homeward in the afternoon. But before they leave the grove by the Ilissus Socrates observes that one should not leave the haunt of Pan without a prayer. And this is his prayer—'Oh auspicious Pan, and ye other deities of this place, grant to me to become beautiful inwardly, and that all my outward goods may prosper my inner soul.'"[1]

It is this kind of priority that the social scientist advocates and endeavours to achieve as he helps to set in order the public affairs of twentieth-century man.

[1] The description is from *Canadian Occasions,* Addresses by Lord Tweedsmuir (John Buchan). Toronto: Musson Book Co., 1941.

BOOK REVIEWS

THREE MEN. By Jean Evans. New York: Alfred A. Knopf, 1954. 297 p.

If this review were a sermon, the text could easily be found in the introduction to this book, by Professor Allport:

> "Good case-writing, as I have said, is hard to come by. . . . Most writers of social and psychological cases are impatient. They do not let the client's whole story filter long enough in their imaginations. Usually, too, they are stilted stylists, being soaked in the professional jargon of sociology, social work, or, worst of all, psychiatry. . . . Case writers naturally reflect the bias of their specialities. In this respect they are not unlike novelists who project their own moral preconceptions upon the characters they create.
>
> "Literature and psychology are the two primary approaches to the study of human personality, each having distinctive advantages. Yet too often does the literary writer ridicule the psychologist, and too often does the latter scorn the insights and methods of literature. A very few autobiographers attempt to combine both approaches; among them one thinks of H. G. Wells and William Ellery Leonard. Still fewer are the instances where the writer of social case histories employs the art of the story-teller while holding himself within the constraints of science. Miss Evans does so, deliberately and with success. If she has not invented a new genre of case-writing, at least she has brought it to new high levels. Science and art are steeds of unlike temperament, and it is no small feat to ride both at once."

Perhaps this is a somewhat more elegant way of putting what Dr. George W. Henry once said to this reviewer, "When writing a report, say what has to be said so that it can be read by a high-school boy."

Miss Evans has taken the stories of three men and has set down what they had to say about themselves and the world they live in. Not only has she used the popular method of setting forth the man's own words, but she has furnished the reader with enough connecting material so that the story is capable of being read not only with profit, but also with interest.

There is nothing unusual about these men. Psychiatrists, psychologists, social workers, prison workers, probation workers meet them every day in the week. All of the classic material is there; the broken homes, the dominating mothers, the inadequate fathers, poverty, sickness, crime and punishment are there as they are in a thousand other printed case studies. What, then, makes Miss Evans' production different? Simply this: she has told us something about three human beings rather than about three numbers out of the archives of institutions. To use Harry Overstreet's phrase, she has made her three men come vividly alive.

First we are given, in all its sickening familiarity, the story of the boy called Johnny Rocco. Everything is there that appears in the pages of those who report on the causes and conditions of criminal behavior as it is manifested in the lives of those who are born and live and die in a slum. Johnny was a juvenile delinquent. He could not adjust. He was rejected by the nice youngsters, and he sought companionship among those who were anything but nice. Discipline was administered at home by an older brother in the form of brutal beatings. Johnny was in and out of children's courts and "reform" schools. A guidance worker thought that he might do better in a Catholic school than in the public schools, but he was more than the sisters could cope with. Somehow his downward progress was stopped, and he managed to make an adjustment in terms of lower-middle-class folkways; he achieved a certain amount of success. There Miss Evans leaves him, married and with a child and a remarkable amount of stability—for him a most unlooked for achievement.

In the man she calls William Miller we see the personification of the wish for obliteration. William comes from a rural variant of the slum—unwanted, despised, and rejected, with a taste of institutional upbringing. A failure in adolescence, he is forced into the army, where he fails once more. His sorry pilgrimage is interspersed with wanderings, rootlessness, and crime. All through his story is seen a desire for punishment for the burden of guilt that has been impressed upon him from earliest childhood. It is small wonder, then, that he goes blind.

He meets with kindness at the hands of those who conduct the institution for the blind to which he has been sent, and is helped toward self-sufficiency. This is the last thing he wants. William is a chronic dependent, and, when he sees the handwriting on the wall, he makes attempts to worsen his condition so that he may once more become the object of attention, even though that attention be punitive and threatening. One sees his futile attempts at sexual maturity in his courtship of women who are plainly mother substitutes. Here, again, is nothing new. All this has been set forth in the textbooks. It is the manner, rather than the matter, that makes these stories so worth the reading.

The last story is that of a homosexual whose contact with reality is tenuous. Like so many homosexuals, he spent far more time in a land peopled with persons and places of his own invention than any safe margin for day-dreaming can allow. Somewhere in childhood he acquired notions that he was too good for the rough-and-tumble existence of a comfortable home. Of course there was the classic mother. His excursions into the affairs of the country-club set, where he was sure he belonged, met with rebuffs. With each succeed-

ing rebuff, he retreated further and further into his private world. Which meant, in essence, that he was preparing himself for the life of a solitary, with occasional excursions into reality to obtain a moment's fleeting sexual gratification. For these moments, he paid, both consciously and unconsciously, in bouts of guilt and remorse.

He ended, as so many like him do, in New York, where he gravitated to a section of the city affected by artists and writers and those who think themselves such. In one of his ventures into the world of rough men, he met with disaster in the way of arrest and probation. Now he lives as some sort of harmless eccentric, still clinging to his delusions, but willing to make a few more compromises with the world as he embraces the discomforts of a garret existence, made possible on a tiny allowance. It is not unlikely that he thinks himself another Toulouse-Lautrec. Perhaps his brush with the law has taught him some caution. He has managed to stay out of trouble for a long while. And that is something.

It is doubtful whether the stories of these three individuals contain a thing that is new or different. But they do show that those who produce learned books could make their wares accessible to many more interested readers than the few to whom the special language of the learned is familiar.

There was once an Oxford don who described the educated man after this wise: He is educated who can, *imprimis,* read the scriptures in their original tongues; *secundus,* have a proper contempt for those who cannot; and, *tertius,* make a little more money than his neighbor. He that hath ears to hear, let him read *Three Men.*

ALFRED A. GROSS

The George W. Henry Foundation,
New York City

PERSONALITY THROUGH PERCEPTION; AN EXPERIMENTAL AND CLINICAL STUDY. By H. A. Witkin, H. B. Lewis, M. Hertzman, K. Machover, P. Bertnall Meisser, and S. Wapner. New York: Harper and Brothers, 1954. 571 p.

This volume reports a long series of important experimental and clinical studies of the way in which different individuals perceive the vertical dimension. The details of methods and findings will be of immediate interest to many specialists. The larger implications are important for all psychologists and should stimulate a minor revolution in psychological thinking.

The initial chapters describe three experimental methods for measuring perception of the vertical. In the rod-and-frame test, the subject is brought blindfolded to a completely darkened room, seated erect in a chair that can be tilted, and placed in front of a

luminous square frame on which is pivoted a luminous rod. In a randomized series of trials, perception of the vertical is tested under three conditions: chair straight and frame tilted 28°; both chair and frame tilted 28° in the same direction; and chair and frame tilted 28° in opposite directions.

In each of these situations the subject is asked to adjust the rod to the true vertical. Most subjects readily and confidently adjust the rod to a position between the true vertical and the tilt of the frame. Some subjects can ignore the visual field and, relying on body sensations, place the rod close to the true vertical. At the other extreme some subjects are dominated by the visual field, unable to use body sensations, and align the rod with the frame, thus producing error scores of 28°. Among these a few completely lose their bearings. To them one side of the titled frame becomes the top resulting in error scores of 62°. Here is an astonishingly large range of individual differences.

In the tilted-room-tilted-chair test, the subject is placed in a small room that can be tilted 56° to the right or left, and is seated in a chair that can be tilted 22° to the right or left. In a series of trials, he is asked to adjust the room to the true vertical and to adjust his chair and body to the vertical. In a third test, the gravitational forces are altered by rotating the tilted room and tilted chair around a circular track. Again there are large individual differences in the error scores.

These tests and several supplementary perceptual tests were administered to a large college population, to patients in a mental hospital, and to children aged eight to seventeen. A correlational analysis shows that the eleven error scores derived from the three test situations are positively intercorrelated—that is, some individuals are consistently dominated by the visual field while others rely on body sensations in their perception of the vertical.

The same populations, or random samples of them, were given an extensive battery of personality tests, including the Rorschach, the thematic-apperception test, the figure-drawing test, the sentence-completion test, and a word-association test. Clinical interviews and questionnaires were also obtained. These materials were quantified into a series of scores, measuring aspects of personality related by hypothesis to the perceptual scores. For the most part these hypotheses are verified. Individuals who make large errors in the perception of the vertical tend to be fearful, inadequate, anxious, constricted, passive, immature, childish, subject to inferiority feelings, conforming to authority, submissive to parents, etc., etc. The six case studies in Chapter XIV are of special interest.

New methods of studying perception and a wealth of new data relating perception to personality constitute an important contribution. An important contribution may be the stimulus to new thinking.

Only yesterday perception was fully explained in terms of sense organs, associated neural pathways, specific stimuli, and field structures. Only yesterday personality defied quantitative measurement with objective stimuli under controlled laboratory conditions. Only yesterday perceptual phenomena were reported in one chapter far removed from the unrelated chapter on personality. The volume that effects three large changes in psychological thinking is apt to stimulate more. New research tools for the study of personality and the know-how of using them together, as illustrated in this volume, promise much for the future.

FRANK K. SHUTTLEWORTH

The City College of New York.

THE JEALOUS CHILD. By Edward Podolsky, M.D. New York: The Philosophical Library, 1954. 147 p.

The Jealous Child might equally well be called *The Troubled Child,* for it deals not only, as one might expect, with sibling rivalry, but also with the many other problems that may cause a child to become jealous of his more fortunate associates.

In the foreword to his book, Dr. Podolsky, who is a member of the Department of Psychiatry of Kings County Hospital, categorizes the causes of jealousy in children as physical, emotional, social, and economic. In the text he deals with specific conditions, explaining how each produces jealousy and outlining what parents and teachers can do to help the child.

The thesis emphasized throughout the book is the consideration that must be given to jealousy as a complication in any case in which the child already has another problem. The boy or girl who sees others more privileged or less handicapped suffers from jealousy as well as from his own particular difficulty. If he is to maintain mental health and achieve some degree of happiness, he must receive help.

Dr. Podolsky devotes most space to the physical disabilities that create jealousy—diseases that greatly restrict the child, such as tuberculosis, diabetes, and rheumatic heart trouble; impairments of speech and hearing; and nervous disorders, including epilepsy, chorea, and cerebral palsy. Each of these presents its own special problems, but the general procedure in all is to provide the child with love and security while trying to develop self-reliance and a breadth of interests to mitigate the handicap.

So distressing are these misfortunes, however, that psychiatric or guidance help of some sort is necessary both for parent and for child, a point that Dr. Podolsky and other writers on the subject usually mention only indirectly. Referring the patient for such assistance should be routine procedure for every doctor who treats a case of serious chronic physical disability.

Social and economic situations that produce jealousy are also discussed—the problems of the unwanted child, the adopted child, the child whose parents are divorced, the stepchild, and so forth. There is also a chapter on the emotionally maladjusted child. No mention is made of the mentally retarded, who constitute a large group and whose problems are serious both for themselves and for society in general.

Much of what is suggested in the book applies to non-handicapped children as well. Every one, in greater or less degree, has some problem of jealousy. It is especially a normal phenomenon in childhood and should be accepted as such. Sections of the book that deal with such topics as the development of self-reliance as a preventive and an antidote to jealousy are of particular value to parents.

The book, however, is especially helpful to those who meet large numbers of children in their work—teachers, ministers, family physicians, etc. Its primary contribution lies in making such workers aware of how jealousy operates as an important component in nearly every problem situation that troubles a child.

RUTH ANNE KOREY

Public School 181, Brooklyn, New York

THE PSYCHOLOGY OF THE CRIMINAL ACT AND PUNISHMENT. By Gregory Zilboorg, M.D. New York: Harcourt Brace and Company, 1954. 141 p.

The winner of the second Isaac Ray Award of the American Psychiatric Association presents in this volume the lectures that he gave at Yale in 1953. Dr. Zilboorg is not only one of the outstanding psychiatrists of this country and a thoughtful student of human behavior; he also is possessed of a fluent and arresting literary style, and his writings on whatever subject are always substantial and enjoyable. This book is fully in line with what we always look for from this author.

In discussing the general topic of crime and punishment, Dr. Zilboorg first takes up that metaphysical phrase found in the McNaghten Rule, "The Nature and Quality of the Act." The rule, he says, applies moralistic criteria to a clinical problem; the phrase "has no meaning—unless we bring it into harmony with the total personality of the criminal."

After a brief chapter on "The Deterrent Effect of Punishment" (which, of course, like other psychiatrists and most serious penologists, he scouts), Dr. Zilboorg considers "Some Differences in Professional Psychology," contrasting the attitudes taught and developed in the physician as compared with the lawyer, the former identifying

with the patient, the latter estranged from the criminal (his client, or the person who is his major concern).

He then takes up "Aggression and Transgression," pointing out the need of integrating reason with adequate feeling tones if the ego is to function "in the direction of conscience."

The next two chapters deal with "The Drive to Punish" and "Further Aspects of Punishment." Dr. Zilboorg quotes Dr. William A. White as saying that the criminal law represents more hostility against the criminal than concern about the safety of the body social, and he suggests that a reason why punishment has become more humane is the greater capacity nowadays in each individual to identify with another individual, thus to some extent putting himself in the place of the criminal. He points out, too, the need of acceptance of the punishment by the offender if any reconstruction of the latter is to be expected.

The closing chapter presents "Some Suggestions About Psychiatry and Psychiatrists." The present system of expert testimony and the avowed goals of the criminal law fail, the author says, to provide for a proper presentation of the psychiatric point of view in court (p. 121). Since it is unlikely that the law will modify its procedure except under pressure from scientific men, he urges a new code of conduct for psychiatric witnesses. Briefly, no psychiatric expert would appear for any side, but only as a friend of the court; he would not accept the concept of legal insanity or attempt to give an opinion as to the accused's responsibility or irresponsibility. Further, no attempt should be made to answer that "logical monstrosity," the hypothetical question.

The book is stimulating, not to say provocative. It is a closely reasoned presentation of the subject, and a valuable addition to the literature on forensic-psychiatric philosophy and practice.

WINFRED OVERHOLSER

Saint Elizabeths Hospital, Washington, D. C.

PSYCHOLOGY IN THE NURSERY SCHOOL. By Nelly Wolffheim, translated by Charles L. Hannam. New York: The Philosophical Library, 1954. 144 p.

Nelly Wolffheim has been active for many years in the field of child education. As early as 1914 a small book of hers appeared in Germany (*Die Erziehliche Beeinflussung und Beschaeftigung Kranker Kinder*). This book on how to deal with physically ill children in the home was written before the author's personal psychoanalysis and training in analytic psychology had influenced her work. The fact that Miss Wolffheim was active as an educator before her analysis gives her a foundation that is notably different from that of a psycho-

analytically trained person who enters the field of child education ready to apply to it a previously acquired viewpoint.

Psychology in the Nursery School presents briefly the psychoanalytic view of child development, with an explanation of basic psychoanalytic ideas and terminology for the benefit of non-analytically oriented readers. In particular, those stages of child growth are discussed which occur during the nursery and kindergarten years. (The "nursery school" of which the author speaks admits children from three to six years old, and apparently sometimes older.) The book describes the functions that a nursery setting can or should serve in the lives of these young children, in aiding the resolution of the Œdipal conflict, in weaning the child gently from his exclusive attachment to the parent, by allowing him to bring into the open feelings that he is required to suppress or to conceal at home (not, of course, to the extent to which this freedom of expression is encouraged in therapy).

The child's relationship to siblings, the significance of this relationship, and its manifestations in the nursery school are discussed. The author describes early expressions of sexuality as observed in the nursery setting and presents some vivid illustrations of "erotically tinged friendships" among small children. She contrasts her viewpoint on such topics as the meaning and function of play for children with the Froebel and Montessory orientations, giving thereby an interesting, if very sketchy, panorama of modern kindergarten methods.

A great deal is said in this small volume on the meaning play activities have for the child. The author stresses the need for free play, minus educational intent, minus adult leadership, incentive, or participation. "Play means a transformation of reality, a wish-fulfillment, an occupation with oneself" (p. 93). In these terms the plea is made against the imposition of adult standards of usefulness which attempt to direct the child's play into so-considered educational and constructive channels.

Some provocative comments are made on the personality of teachers and their motivation in choosing this profession: "Everything in her drives the teacher to interfere, to improve and to instruct, indeed she would not have become a teacher at all had not the make-up of her emotional life urged her to this sort of activity." Those who will find more than a grain of truth in this statement will be interested to know how such a basic need on the part of teachers can be dealt with. This book does not claim to offer an answer, but it does give food for further thought.

While this book represents a viewpoint steeped in many years of practical experience, its scope is too limited to allow a sufficiently convincing presentation of an educational method and its effects on

the children. What is offered here is a somewhat loose, clinical account, with short case illustrations and some vivid and interesting parenthetic remarks. One misses, however, a more systematic and more objective recording of child behavior, a greater separation between fact and its psychoanalytic interpretation. At times the book appears to be more of a statement of faith than a clinical evaluation.

For this reason, it will not be a book to persuade sceptics of Freudian theory (if that could ever be done by printed words!), nor can it, in my opinion, convey successfully to non-analytically oriented readers how the application of psychoanalytic principles would benefit the child. The psychoanalytically oriented reader, interested in nursery-school education, who can accept the interpretations given here, because his own thinking concurs with it, should find this little book interesting and stimulating. Here again the lack of more detailed reporting of child behavior and of the attitudes and actions of the staff is regrettable.

This book makes very useful contribution to the literature on the subject, but one wishes for more than she has given here of the good things that Nelly Wolffheim has to offer out of her many years of experience.

RENEE J. REENS

New York City

ROOFS FOR THE FAMILY: BUILDING A CENTER FOR THE CARE OF CHILDREN. By Eva Burmeister. New York: Columbia University Press, 1954. 203 p.

This is a genial, warm, informative sequel to Miss Burmeister's *Forty-five in the Family*. Both of these readable books are "musts" for all who are concerned with the institutional care of children—board members, case-workers, and house mothers. They are also good reading and profitable reading for parents and others interested in children and how they feel and behave when confronted with childhood's greatest trauma—separation from their own parents. These two short books convey an attitude toward and feeling about children who are distressed, and therefore troublesome, that is sound and heart-warming.

In this second book, Miss Burmeister describes the planning for, building of, and moving into a modern cottage-type institution from a venerable, traditional congregate children's home. In a style that is simple, easy, and conversational, the author lets the reader participate in momentous decisions, frustrations, and confusions, high comedy and near tragedy.

Miss Burmeister thinks, feels, and writes in terms of an institutional

family. All families are integrated constellations of potentially highly discordant individuals. The Lakeside Home of 45 children (reduced to about 30 during the period covered by this volume) with its board of directors, house mothers, case-workers, student helpers, cook, and handy man, and its miscellaneous pets, is a particularly lively family. Any family that has ever moved from the kind of old house that has lots of attic space, full of treasures dear to the imagination of children, knows of the heartache decisions that go into planning what to take along into brand-new, carefully planned, much more efficient new quarters.

The children of this family were fundamentally insecure. The security they had begun to achieve at the old Lakeside Home had much to do with the solidity and apparent permanence of the old home, whose inefficiencies and inconveniences never bothered the children. One senses on every page Miss Burmeister's and the house mothers' concern for the latent feelings of the always active children, even when, as administrators and planners, they had to devote most waking hours to architectural, structural, and decorating problems—not to speak of packing, getting rid of, or refinishing furniture and carrying on the hectic daily life of the institutional family.

In an informal, but explicit manner, the author discusses the pro's and con's of the decision to build a cottage-type institution, where groups would be small and homogeneous as regards age and sex. As one reads, one understands and agrees that the decisions reached by Miss Burmeister and her board were wise and considered and arrived at in terms of the needs of children, from elementary-school age into adolescence, who, for one reason or another, cannot live in their own homes and are not easily placeable in foster homes. Miss Burmeister includes floor plans and careful descriptions of the cottages as they were finally conceived and constructed that should prove invaluable to boards and administrators of children's homes confronted with a building program.

Though, as the title and subtitle imply, this book is primarily about planning and building "roofs for the family," it is permeated throughout by the attitude that it is the personnel—the people who live with and care for the children—that make the institution. The "roofs"—whether it be one big roof or a lot of smaller roofs—are secondary and are important only as they finally serve the needs of the children and the staff. Never does Miss Burmeister allow her board, her staff, or her readers to forget that the home is for the children and the people make the home.

The houses in which families live are important and can be planned to make family life easier and more congenial. In this book the author makes a sincere and successful effort to share an experience, so that others can profit from Lakeside's thinking and planning and from

successes achieved and mistakes made. However, as one reads this book, one feels that the coöperative planning and the shared experience helped make this good family a still better family.

FLORENCE CLOTHIER
New England Home for Little Wanderers,
Boston, Massachusetts

WARTIME PSYCHIATRY: A COMPENDIUM OF THE INTERNATIONAL LITERATURE. Edited by Nolan D. C. Lewis, M.D. and Bernice Engle. New York: Oxford University Press, 1954. 952 p.

The field of mental hygiene is richer as a result of the availability of this compendium of the international literature of "wartime psychiatry." The volume was prepared at the New York State Psychiatric Institute in New York City. It was made possible by a grant of the Research Committee on Dementia Praecox, of The National Association for Mental Health, from funds supplied by the Supreme Council 33° Scottish Rite Northern Jurisdiction, U.S.A.

The editors state that they have included most of the important material on psychiatry in World War II. This includes articles, books, and other publications that appeared during 1940-48; a few "outstanding studies" of 1949-50 are also said to be included. Some 1,200 articles are either summarized in concise, reportorial synopsis, or cited as additional reference in the first thirteen sections. The fourteenth section includes reprinted book reviews of 29 different volumes that have appeared in various professional journals. Additional books are noted by title in several areas of interest. There is an authors index, but no ready reference to the articles that are summarized in the volume.

Each of the first thirteen sections is preceded by observations of the editors on the body of data to be presented. These observations add materially to the content of the compendium, and are refreshing in their introduction to the papers that appear in each section. A more elaborate introduction to the volume, with a minimal historical background, might have added somewhat to the orientation. The general questions posed in the preface pave the way for an understanding of the clinical data subsequently reported.

The material must have been unwieldy to organize, not only quantitatively, but more particularly in so far as it affected the developing of categories of more homogeneous quality. Thus, some categories relate to psychiatric function—*e.g.*, Administration, Aviation; others are pointed toward pathology—*e.g.*, Psychoses, Psychoneuroses. Inevitably some material crosses both categories and we find sections and selections—*e.g.*, Problems of Combat, Demobilization, Rehabilitation, Selection, Induction and Training—all of which have adminis-

trative implications. This is a minor criticism that might easily be overcome if the book had an index with cross references.

Section XII, which carries digests of some 150 papers, is the largest and contains some of the least widely distributed and known efforts. Under the heading, "General and Miscellaneous Problems," the international flavor of psychiatry is in greatest evidence. Much of the comparative experience over the world and in various cultures appears in this section. These data, which were being observed simultaneously with the production of "allied" psychiatry, give considerable perspective to the variety of adaptive problems faced by humans on all sides and fronts during a global war. The sequelæ of war are also included to round out the picture.

The section, paradoxically enough, in which the smallest number of articles (38) are digested is titled, "Lessons to be Learned." The reviewer prefers to believe that this is a reflection of the cut-off date of the compendium rather than a quantitative expression of interest by the field. Two volumes not included in the book section would tend to support this belief. *Adventure in Mental Health: Psychiatric Social Work with the Armed Forces in World War II,* edited by Henry S. Maas (New York: Columbia University Press, 1951) makes a strong plea to adapt the experiences gained in military service to civilian use. Also much is to be expected from the Human Resources Studies at Columbia University. Their recently published *Psychiatry and Military Manpower Policy* (New York: Kings Crown Press, 1953) is aptly subtitled, *A Reappraisal of the Experience in World War II.*

The compendium itself is one of the guarantees that mental hygiene will continue to avail itself of the clinical observations and experiences of wartime psychiatry. As a single resource volume, it deserves a place in every professional library.

HARRY L. FREEDMAN

Psychiatric Service, Clinton Prison,
Dannemora, New York

UNDERSTANDING THE JAPANESE MIND. By James Clark Moloney, M.D. New York: Philosophical Library, 1954. 252 p.

Dr. James Clark Moloney has the interesting thesis that a study of the preconceptions and practices of Japanese psychoanalysis would give us an insight into Japanese character structure and culture. One difficulty with this, methodologically, is the unimportance of psychoanalysis in Japan, the fewness of its practitioners (and hence their possible non-representativeness), and their evidently inadequate training. Nevertheless, despite these formidable obstacles, Dr. Moloney has arrived at conclusions that well accord with the assess-

ment of other observers: that the Japanese are basically sado-masochistic and the product of hierarchic, authoritarian social pressures—which is to say that the Japanese bear in themselves, and reproduce in their children, an essentially compulsive, hostility-laden, but conformist character structure.

Dr. Moloney considers that the relationship of the Japanese mother and child is characteristically warm and close, but that the child soon learns from the mother's own attitudes toward males a submissiveness toward authority so deep-rooted that rebellion against authority or against any bearer of greater power is quite unthinkable. The result is that buried Œdipal hostilities are displaced upon secondary objects: women, weaker social classes, and even such movements as Buddhism and Christianity. Toward foreigners the Japanese attitude is markedly ambivalent, at times slavishly copying and identifying with their power, and at other times using foreigners to vent hostility upon, as impugners of the divinely ordained imperial way. "In fact," Dr. Moloney says (pp. 59-60), "these institutions [*ko, chu, kazan, giri,* and *enryo,* which are various obligations and disciplines enforcing conformity] are dramatized almost as post-hypnotic suggestions, induced by a maternal hypnotist. . . . The rigid Japanese patriarchy is like [a] rigid bar, but the bar is wielded by the phantom of the mother who originally indoctrinated the child with the patriarchal system."

Quite properly, Dr. Moloney sees this as counter to the aims and methods of Western psychoanalysis, in so far as it is expressed in Japanese "psychoanalysis." In this connection it is interesting to note that the Japanese analyst, Kosawa, "departed from the classical Œdipus complex of Freud because it implies father-murder, which is untenable in Japanese culture. He substitutes the Azase or mother-murder complex, because, though rare, it would be more comprehensible to a Japanese" (p. 168).

Dr. Moloney believes that Japanese psychoanalysis, for all its feckless copying of its Western original, has been so syncretized to Japanese culture as to have lost entirely its original libertarian spirit: "Instead of endeavoring, as do occidental psychoanalysts, to free the individual from his inner thongs, the Japanese analyst actually tightens these thongs" (p. 213).

The book itself is rambling, stylistically somewhat undisciplined, and occasionally ingenuous. It lacks detached scholarly nuance and balance, and the thesis is presented with a tone of unrelieved insistence and even indignation that disturbs one with uncertainty at times—for surely so complex a subject as a whole nation is not so logically neat and one-sided. Nevertheless, we believe that the author has demonstrated and adequately documented a strong case for the proposition that

any intellectual discipline, including psychoanalysis, has its "sociology of knowledge" context, and can be seen in its Japanese version to have undergone marked cultural change. Dr. Moloney's approach is interesting, original, and useful.

WESTON LA BARRE

Durham, North Carolina

PSYCHOLOGY—THE NURSE AND THE PATIENT. By Doris M. Odlum. Second edition. New York: The Philosophical Library, 1954. 168 p.

Dr. Odlum prepared this text to assist student nurses in England prepare for their examinations as "state registered nurses." It is planned to meet the requirements of the syllabus as it applies to psychology and to serve as a guide to those who are instructing students. It is a small volume, consisting of a hundred and sixty pages and an index. The subject matter is divided into nineteen chapters.

Old and new concepts of the development of the higher mental faculties are mentioned. The importance of inborn mental factors, how they are modified by environment and experience, and the part played by emotion in the development of character and personality are discussed.

It is quite likely that student nurses in England have more extensive teaching in psychology, as a preliminary requirement in their nursing education, than is given in this country. In that case, this volume would serve as an outline guide for review study.

In chapters 8 and 9, the effect that hospitalization has on patients is sympathetically presented. Confronted with the pain and incapacity involved in illness, the usual reaction is fear and some resentment. When a patient is admitted to a hospital, the nurse meets a person with a complication of physical ailment, mental confusion, and behavior that may present difficulty in adjustment.

Dr. Odlum stresses the need that all patients have to understand their fears and offers wise counsel to the nurse as to her application of the teaching she has had on patients' fears and personal reactions to the hospital situation.

The importance of the nurse's attitude and personal interest in patients is stressed and practical examples are cited for her guidance. This seems to be of special importance at the present time, when modern techniques and scientific developments have shortened the time patients spend in hospitals. The nurse and the patient have little time to get acquainted and the patient is usually in an acute phase of the illness that brought him to the hospital, so that his normal, everyday behavior hardly emerges. The nurse should have the fact

stressed that patients comprehend a great deal more than they can express and that her kindness will be appreciated, even though the patient cannot say so.

In Chapter 10 some special problems in nursing are presented. The surgical conditions, especially those involving mutilating operations, with the disturbing emotional reaction that usually accompanies such procedures, are sympathetically discussed. The problems involved in getting patients out of bed soon after operations, the use of sedatives and hypnotics, and the fact that individuals differ in their need for assistance, are also presented. Problems involved in caring for children, the long continued illnesses, and the elderly patient are considered briefly, but helpfully.

There may be differences of opinion on some details and the terminology in some cases is different from ours. For example, the "ward sister" is the charge nurse, and reference is made to the "trolley," when we would say "stretcher." There are also differences in disease classification as presented in this book and as used in the United States, but the conditions described will be readily recognized.

There probably will be some difference of opinion as to the nurse's responsibility and manner of dealing with the patient who asks her, "Am I going to die?" Despite the decision of the "medical 'brains trust,'" which presented an "almost unanimous decision" that in "no circumstances should a patient be told categorically that he or she is about to die," some circumstances and certainly some patients might make necessary a change in such a decision. Also, if the nurse assumes a protecting attitude and accepts the patient's trust and confidence, when such a question is put to her, she should meet it with more evidence of interest than "some non-committal remark such as: 'I am not the person to ask. It would be better for you to ask the ward sister or the doctor.'"

The young student nurse should not assume the responsibility of giving an opinion, and she could say that she would have to ask the doctor to tell the patient what he wants to know. There are ways of saying what must be said; the important thing is to convey assurance to the patient that something will be done to provide the help he requests.

Five chapters have been added in this, the second, edition of the book. One deals with the development of human behavior in the family and in society, while the concluding four chapters present neuroses and psychoses and their treatment. Condensing subjects of such magnitude into so few words permits only the briefest mention of the high lights. Again, it may be supposed that the student in England has a more extensive background of instruction and clinical experience.

The little book should be useful and interesting to student nurses and to others concerned with the care of patients. Where the terms used differ from those that we are accustomed to, the research required to interpret them may be of value in stimulating further study.

MARY E. CORCORAN

New York City

THE INITIAL INTERVIEW IN PSYCHIATRIC PRACTICE. By Merton Gill, Richard Newman, and Fredrick C. Redlich. New York: International Universities Press, 1954. 423 p.

This small volume and its accompanying recorded interviews are very important contributions to the philosophy and technique of the initial interviewing of psychiatric patients. The authors write well and significantly about a phase of psychiatry that has not received the attention it deserves. The thesis is presented that "systematic inquiry into specific sections of the life history or the current status" of patients should be abandoned. Instead, the initial interview should be developed primarily on the basis of the patient's leads.

The aims of such interviewing are stated as: the promotion of rapport between patient and therapist; appraisal of the patient's psychological status, under the headings of nature of the disorder, motivation for psychotherapy, capacity for psychotherapy, and external factors affecting the initiation of this therapy; and reinforcement of the patient's wish to continue therapy if appropriate. The types of interviewing to be avoided are stated as: diagnostic fact-finding in the "medical tradition"; client-centered non-directive interviewing; and the modified diagnostic approach.

The authors' point of view would seem to apply to all psychotherapeutically oriented initial interviews. However, it must be stated that in modern psychiatric practice this is already the case, though the rationale and terms employed may vary with the therapist's particular school affiliation. It must not be forgotten that diagnosing will continue to play a very important rôle in the services rendered by outpatient clinics. Often cases are referred to these clinics specifically for such determinations, and the use of interviewing techniques promulgated in this text should not relegate diagnostic efforts to a second-rate status. Moreover, this type of interview need not be so sterile as the authors imply. It is not the specifically spoken word or question so much as the doctor's attitude that differentiates an informative, therapeutic interview from one quite the opposite.

In this connection, it should be stressed that much more than sympathetic listening is required, especially the variety with obligatory

connotations. The therapist must be sufficiently flexible to be able to run the gamut from collaboration with spontaneously developing material to assumption of a more directive rôle where necessary. Admittedly the learning of appropriate interventions is a complex task, and although not stressed enough by the authors, the very nature of the comments accompanying the verbatim transcripts shapes up the problem very well. Probably the only way to study this is by the method recommended in the text.

Though not mentioned, there would seem to be a place in the initial interview for something comparable to that part of the medical examination called the system review, especially as it pertains to the present status of the patient. The mental-status examination does not approach what is needed, although it is often taken for this. What is recommended is a major attempt to go over with the patient his present behavior and attitudes with "significant others" in his current life situation. This would offer the opportunity to gain understanding of the patient as he functions now, from the standpoint not only of his pathology, but of his assets as well. Too many initial interviews are recitals of what is wrong with the patient, with consequent elaboration of ego-deflating tendencies, while his areas of adequate and better function are given little attention. The importance of understanding the patient as a person and not merely as a collection of pathological manifestations is essential to the emergence of a useful relationship between him and the therapist. It would be unfortunate if depreciation of "systematic inquiries" should cause this aspect of initial interviewing to be overlooked.

The authors are to be commended for the recordings and the verbatim transcripts, with the accompanying discussion. These have the effect of bringing the interviews to life and making the reader an active participant in the process. As they indicate, the teaching and research value of this approach is enormous. It appears to be an effective way for the therapist to define what it is he is doing, and to foster that attitude of self-appraisal that makes for scientific progress. The section on problems of recording summarizes the implications of this technique and can be read with profit by any one anticipating studies in this area.

This book is extremely stimulating and provocative. It is bound to excite considerable comment and is highly recommended.

LESTER H. GLIEDMAN

Phipps Psychiatric Clinic,
Johns Hopkins Hospital

NOTES AND COMMENTS

NAMH Psychiatric Aide Achievement Awards

For the eighth consecutive year, NAMH will honor psychiatric aides selected as the most outstanding in the country by conferring the Annual Psychiatric Aide Achievement Awards during May.

The Psychiatric Aide Award program was set up to help focus attention on the importance of the rôle played by psychiatric aides in the treatment and care of the mentally ill; to help gain for aides adequate recognition and acceptance; to encourage the promotion of higher standards of on-the-ward care.

Nominations of candidates for the 1954 Awards have been invited from all eligible public and governmental mental hospitals in the United States and its territories. As in previous years, each participating hospital will send NAMH nominating material on the psychiatric aide employed there who has been selected by his associates, his patients, and his fellow-citizens in the community as "most representative of the collective advancement rendered by the aide group to the better ward care and the well-being of the patients during the calendar year 1954."

Each award will be made on the basis of the following qualifications: (1) Examples of unusually outstanding services performed in behalf of the patients during the past year; (2) evidence of skill, initiative and imagination shown in the discharge of duties and indication of kindness and devotion to patients; (3) citizenship, as demonstrated by off-duty participation in the life of the hospital and his community.

The materials submitted by each hospital for its candidate will be reviewed by the NAMH Award Committee, which will determine eligibility of the candidate and acceptability of entries in accordance with NAMH rules governing awards. Identical awards and certificates will be presented to each psychiatric aide whose nomination is approved by the Committee. Closing date for submission of entries for this year's awards was April 1. Announcement of the Award winners will be made during the month of May.

Mental Health Week, 1955

More than 5,000 national, state, and local groups throughout the United States and territories will participate in observances marking the 7th Annual Mental Health Week May 1 to 7. Coördinated by

NAMH, in co-sponsorship with the National Institute of Mental Health, U. S. Department of Health, Education, and Welfare, Mental Health Week is planned to help foster better public understanding of the problems of mental illness, the importance of good mental health, and to rally support for the fight against mental illness.

In addition to the many educational events, a nationwide campaign to raise $5,000,000 for the fight against mental illness will be launched during Mental Health Week by NAMH and affiliated State and Local Mental Health Associations. Funds raised in the campaign will be used for research, training of personnel, education, and community services carried on by the Mental Health Associations.

Centennial of Saint Elizabeths Hospital

This year Saint Elizabeths Hospital, Washington, D. C., celebrates its centennial—one hundred years of service of which it can be justly proud. Established by an Act of Congress on March 3, 1885, as the Government Hospital for the Insane, St. Elizabeths has grown from an institution with just 75 patients to become one of the world's largest institutions for the care and treatment of the mentally ill. Today there are on the rolls of the hospital approximately 7,500 patients.

Credit for the establishment of St. Elizabeths goes to Dorothea Lynde Dix, the indomitable pioneer in the mental health field. Miss Dix was instrumental in obtaining the original appropriation from Congress, selected the site for the hospital, chose the first superintendent, and had much to do with the construction and early operation of the hospital. This year her name will be given to the new 420-bed admission and treatment building at St. Elizabeths—the Dorothea Lynde Dix Memorial Pavilion.

From its very beginning, Saint Elizabeths has been a leader in its field, and over the years has earned a high reputation both in this country and abroad. The history of its one-hundred years is marked by many outstanding achievements and contributions to advancements in the treatment and care of the mentally ill. Never identified with any single school of psychiatric thought, it has been proud of its eclectic approach.

It has been noted for its pioneering efforts in establishing neuropathology and clinical psychology departments. It has trained thousands of psychiatrists, psychologists, psychiatric nurses, social workers, occupational therapists and others engaged in treatment of the mentally ill. It was the first hospital in America to use the malaria treatment for paresis and is believed to have been the first American hospital to use the psychoanalytic technique in the treatment of

schizophrenia. It is the only public mental hospital in America which offers an AMA-approved general internship.

On May 5 and 6, St. Elizabeths will hold a number of special centennial celebration events. These will include: a meeting of prominent psychiatrists and other mental health authorities of international repute, the dedication of the new Dorothea Dix Pavilion, and several performances of a pageant based on dramatic episodes in the life of Dorothea Dix and the early treatment of the mentally ill—a play planned, written and acted by patients of St. Elizabeths.

The annals of this hospital record one hundred years of progress in American psychiatry which may well be celebrated with pride.

National Hospital Week

May 8th to 14th will be observed throughout the country as National Hospital Week with the theme "Your Hospital—A Tradition of Service." Sponsored by the American Hospital Association, National Hospital Week is traditionally scheduled around the May 12 birthday of Florence Nightingale.

Thorazine and Reserpin Adopted for Treatment of Patients in New York State Mental Hospitals

As the result of broad-scale research with new drugs in the treatment of mental illness, the New York State Dept. of Mental Hygiene has decided to use thorazine and reserpin in the treatment of "all suitable patients in Department of Mental Hygiene institutions," according to an announcement by Dr. Arthur W. Pense, Acting Commissioner of Mental Hygiene, following the conclusion of intensive test projects.

The tests with the new drugs were conducted in 20 of the mental hygiene institutions under the direction of Dr. Henry Brill, assistant commissioner in charge of research. "While these are not 'miracle drugs' and can in no way be considered a cure-all," Dr. Brill stated, "there is no question that the use of thorazine (also known as chlorpromazine) and reserpin (also known as serpasil) represents one of the most significant advances in the history of psychiatric therapy."

Some 1,400 patients in all age groups, with varying physical conditions and mental diagnoses, have received thorazine since May, 1954, he reported, and 700 received reserpin. It was found that "about 70 per cent of properly-selected patients have shown significant improvement, and it is expected that this type of treatment will contribute materially to the recovery and release of patients."

Dr. Brill noted that much additional research is needed and that these new drugs will "in all probability be followed by more refined products, even more effective and satisfactory."

V. A. Residencies in Psychiatry Announced

The Veterans Administration Hospital in Lyons, N. J., has announced the availability of residencies in psychiatry, for a one- to two-year period, which are fully accredited by the American Board of Psychiatry and Neurology. The training program consists of lectures, conferences, and seminars under the direction of the Department of Psychiatry, New York Medical College, and offers intensive training both intramural and through rotation in special hospitals and clinics in adjacent areas. There is, in addition, a series of guest lecturers, as well as an annual institute at the hospital. Training may commence at any time. Inquiries should be directed to C. N. Baganz, M.D., Manager, Veterans Administration Hospital, Lyons, N. J.

Training of Psychiatric Aides Discussed at Meeting

The training needs of psychiatric aides was the principal topic discussed at a two-day meeting sponsored by the American Nurses Association and the National League of Nursing held in New York the past November. Various types of psychiatric-aide training programs were discussed at length, with consideration of the relative values of "pre-service" and "on-the-job" training programs.

There was general agreement that on-the-job training is greatly needed, and should be extended and improved. It was felt also that it is of paramount importance that nurses now teaching in on-the-job training programs would be helped by attendance at workshops and short courses to do better work than many of them are now prepared to do.

Pre-service education was defined by the group as "preparation including planned clinical practice, which is provided in a block of time preceding assignment." It should prepare a worker for employment not in one institution, but in all situations of a similar type, it was agreed. Also emphasized were the important points that: pre-service education of psychiatric aides, to whom the day-to-day care of hundreds of thousands of mentally ill patients is delegated, is an absolute necessity, if that care is to be improved; that mechanical techniques can readily be taught on the job, but education for understanding responsibility can be offered more economically and more successfully in a planned education program; and that it is only in pre-service programs that students are enrolled as students and are given adequate time and opportunity for study and reflection.

The pros and cons of establishing such programs under junior college, vocational education, or hospital auspices were also discussed. It was agreed that effort should be made to obtain foundation or

government support for the establishment of two or three programs under different types of control so that comparative data could be obtained. Recruitment and training of teachers should also be given particular attention at this time, it was noted.

Those present at the meeting included nurses, psychiatrists, and psychiatric aides representing public and private psychiatric hospitals, schools of nursing and representatives of the following organizations: American Hospital Association, American Medical Association, National Federation of Licensed Practical Nurses, National Association for Mental Health, American Psychiatric Association, Group for the Advancement of Psychiatry, Council of State Governments, U. S. Department of Health, Education and Welfare, Veterans Administration and the Federation of State, County and Municipal Employes.

Report Published on Preparing the Mentally Retarded for Successful Employment

Mentally retarded youths now considered unemployable can be prepared for successful jobs in competitive industry, if vocational education and planning for them is started early enough, a report issued by the Jewish Child Care Association of New York and the Federation Employment and Guidance Service points out. The report is based on an intensive study of individualized work with 46 boys and girls from 13 to 16 years of age who, in addition to requiring care away from their own homes because of family situations, performed at a retarded level. Most of the children who reached working age in the course of the specialized training given under the program were employed on jobs where they received the going rate of pay. The report further noted that they stayed on the job with a "remarkable degree of stability." Citing the statement that 60 per cent of all people who lose their jobs do so for reasons of inability to get along with their co-workers rather than for inability to perform the duties of the job, the report says: "It would seem that one of the most important areas to deal with in conditioning the mentally retarded is that of social adjustment." While the gap between employability and the actual placement on jobs for the retarded can be closed by more widespread employer enlightenment, job adjustment and job stability depend to a significant degree on social relationships with co-workers, foremen and employers, it was stressed.

Newsletters of Two New York Youth Agencies Available

The New York State Youth Commission and the New York City Youth Board have offered to send their respective newsletters to interested persons and agencies outside of the state without charge.

The Youth Commission publishes *Youth Service News* five times a year. The bulletin emphasizes activities relating to the prevention of delinquency (recreation projects, mental health programs, etc.) and includes statistical data and items concerning treatment services. Requests for this bulletin should be addressed to New York State Youth Commission, 66 Beaver St., Albany 7, N. Y.

The *Youth Board News,* issued by the New York City Youth Board, is a monthly publication devoted to describing various parts of the agency's program for the prevention of delinquency. Requests for free subscriptions should be sent to New York City Youth Board, 500 Park Avenue, New York 21, N. Y.

Summer Courses and Workshops Scheduled

A workshop on "Individual Differences in Elementary and Secondary School Children" will be held at the Catholic University of America, Washington, D. C., June 10 to 21, 1955. Planned for supervisors, principals, teachers, and lay persons interested in the field of special education, the ten-day course will include lectures and seminars on: the mentally retarded, the socially maladjusted, remedial reading, the emotionally disturbed, mental health, testing, the cerebral palsied, child guidance, psychological diagnosis, administrative procedures and other pertinent topics. The Rev. William F. Jenks, C.SS.R., will be the Director of the Workshop. This workshop will be followed by a summer course for teachers of the partially-seeing and the blind, June 27 to August 6th. Inquiries should be sent to the Catholic University of America, Washington 17, D. C.

The American University of Washington, D. C. will offer its sixth institute on human relations June 20 through July 11th, 1955. The Institute will focus on "Inter-Group Understanding" and will take up problems such as discrimination, prejudice, bigotry and other racial and religious inter-group problems. For information write to Charles K. Trueblood, Chairman, Dept. of Psychology, American University, Washington 6, D. C.

The practice of including children-with-special-needs in normal school situations will be examined in all its aspects by elementary and nursery school teachers in a four-week summer workshop program to be presented by Pacific Oaks Friends School, in Pasadena, and Occidental College, Los Angeles. The Director of the workshop will be Clara Mannshardt, Director of Education, Temple City Unified School District. The chief aim of the workshop will be to investigate the ways the teacher and the community may meet the needs of a widely varied group of children including the gifted child, the normal child, the physically impaired or emotionally disturbed child, and to help them to develop to the limit of their capacities. Meeting

with the study groups will be specialists in education, psychology, psychiatry, medicine and social work. Study groups will meet daily June 27th through July 22nd. Further information may be obtained from the Pacific Oaks Friends' School, 714 West California Street, Pasadena 2, California.

St. Johns University Institute for Mental Health at Collegeville, Minn., has been given a grant by the Hamm Foundation of St. Paul to conduct three week-long workshops in Pastoral Psychology for clergymen. With the theme "Psychotherapy and Pastoral Problems," the workshops will be open to clergymen of all faiths who are interested in mental health problems. The three workshops have been scheduled for August 1 to 5, 8 to 12, and 16 to 20. The first series of workshops was held by St. Johns last August and, according to the report of the Institute's Board of Directors, was most successful. Originally planned for clergymen of the upper-midwest, the series attracted participants from many parts of the country.

A summer workshop in Family Life Education has been scheduled by the Central Washington College of Education, Ellinsburg, Washington, July 18 through 29. Open to teachers, counselors, administrators, youth organization leaders, and parents, the workshop will take up topics such as the evaluation of teaching methods, how to acquire understanding necessary for effective work in family life education; how to become familiar with common youth problems.

Three specialists in child development, psychiatry, and sociology will conduct a three-week workshop in family relations at Syracuse University, July 5 to 22. The workshop will help teachers, school nurses, parents and religious leaders develop a deeper understanding of how the American family affects the behavior of boys and girls in the public high schools, and give participants an opportunity to gain insight into the needs and problems of a child and his family. The workshop will be staffed by Dr. William P. Mangin, instructor in Sociology and Anthropology, and Dr. Elizabeth Manwell, Asst. Professor in Family Relations, both of Syracuse University faculty; and Dr. Edward Stainbrook, Chairman of the Dept. of Psychiatry, State University of New York, Upstate Medical Center. Inquiries about the workshop should be addressed to Dr. Mangin, Dept. of Sociology and Anthropology, Syracuse University, Syracuse, N. Y.

The New York Academy of Medicine has scheduled a graduate fortnight on "Problems of the Aging" which will be held in New York City, October 10 to 21, with Dr. Clarence de la Chapelle as chairman. Morning and evening sessions will be held. Primarily planned as a program of orientation in geriatrics for physicians, it will be open to laymen as well. For further details write Dr. Roger L. Craig, 2 East 103 St., New York City.

In Praise of Volunteers

"Indispensable" is how Spring Grove State Hospital in Baltimore thinks of its corps of volunteers, which played a major rôle in assisting the hospital establish a department for psychiatric research.

In a recent letter to NAMH, Dr. Albert A. Kurland, Director of Medical Research at Spring Grove, wrote: "This hospital, now over 150 years old, only a little over a year ago established its first department for psychiatric research. With very limited funds and no supporting staff, it would have been practically impossible to get underway, except for the rôle which the Volunteer Service played.

"It made local lay organizations acquainted with our needs for personnel who would come in and help us with the clerical and secretarial aspects of the overwhelming mass of scientific data which accumulates with any vigorous program and which must be kept organized to make it meaningful. It secured funds to procure equipment which had to be had at the moment and could not wait for next year's budget. It was this proverbial supplying of the 'nail for the horse's shoe' by the Volunteer Service which again and again turned a feeling of frustration into a ray of hope, allowing us to find our way once again.

"Another extremely important rôle which the Volunteer Service played was the setting up of an organization which we have called the Friends of Psychiatric Research. The members, as a result of their participation, get a more intimate acquaintance with the problems that their own state psychiatric hospital is struggling with from the research standpoint, and of our attempts to master them.

"These volunteers become the minute men and women in our struggle to make this hospital an active front in the assault on mental illness by their readiness to contribute time and services.

"The knowledge that there is such a supporting organization always at our command has given us a maneuverability of which, even in our most optimistic moments, we could not have dreamed. It has built a bulwark against the feelings of frustration and uncertainty brought about by the vicissitudes of budgetary restrictions and changes. Whatever happens now, we have the feeling that this source of help is something we can turn to in an emergency. Of course, this means also that we must learn our next lesson carefully, namely, the most tactful and non-taxing way of conserving these resources.

"I wish to express my appreciation for this opportunity to relay to you this new development in our hospital and hope that others may be encouraged to investigate this potential asset in their own surroundings."

Recent Publications

The National Health Council's new publication *Health Careers Guidebook* should win a generous measure of appreciation from vocational counselors and students exploring possibilities for future careers. In 160 attractive pages of text and pictures, the *Guidebook* presents a most comprehensive picture of 156 different occupations in all types of health services. Not an occupational "dictionary," it gives lively, human facts which should be of interest and great help to young people and school counselors. The information is authoritative, objective, and up-to-date. Each of the health career briefings was reviewed by an appropriate professional or health organization and carries its name as a source of further information. The *Guidebook* stresses honestly and objectively the high cost of professional education in some of the health fields, but also points out many occupations which require a minimum amount of training beyond high school. The *Guidebook* was pre-tested by students and teachers in 30 high schools before its nationwide distribution was begun last month. Because of the widespread interest and enthusiasm among the prepublication readers, students, counselors, educators, and health experts, a second book took form, entitled *Partners for Health*. This is a brief edition, which presents the same general introductory view as the *Guidebook* and is designed for supplementary school and community use. Publication and distribution of the *Guidebook* was made possible through the support of the Equitable Life Assurance Society of the United States, a sustaining member of the National Health Council.

A leaflet on mental health clinics, designed to explain to laymen the importance of clinics and to inform people how clinics are conducted, what treatment is given, etc., has been issued by the Department of National Health and Welfare, Information Services division, Ottawa, Ontario. In addition to popularly-written paragraphs giving a good picture of mental health clinics in general, the leaflet includes a "rough guide" to help people recognize when outside expert advice is needed. Particular emphasis is given to Child Guidance Clinics.

Removing Blocks to Mental Health in School is the title of a new booklet prepared by a committee of the staff of the New York State Education Dept. which has served as a liaison group with the State Mental Health Commission. The attractive, illustrated publication calls attention to some of the conditions frequently met in schools which may hamper the effectiveness of a good mental health program, and suggests an approach to the study of basic conditions essential for the development of the best mental health in schools. Seventeen "typical" situations are taken up. The pamphlet does not attempt

to suggest specific programs, but should be a helpful guide for teachers, principals, and parents concerned with providing a school atmosphere conducive to good mental health.

The Committee on Coöperation with Governmental Agencies of the Group for the Advancement of Psychiatry has published a report on homosexuality, with particular emphasis on this problem in governmental agencies. The eight-page bulletin (GAP Report No. 30) was compiled with the objective of defining and describing homosexual behavior from a medical and social point of view in accordance with accepted principles. The report includes a history, definition, etiology, treatment of homosexuality, and a section on homosexuality in military and other federal agencies.